Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Verna Elizabeth Owens Tome 2່ວີ່ 1ື 0 10:34 A.M December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cecil Calvert Manor Health Care Center Rising Sun Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 🗆 M 2 😾 F Months Hours $May^{(Month}6^{Day}$ 219-16-3103 Director 87 Usual Residence of Decedent Show if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🙀 No Maryland Cecil Colora 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 838 Nesbitt Road 21917 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important if item 27 is marked other the any injury or other the Completed by 1 Never Married 2 Married Yes 2 No 1 ☐ Yes 2 💢 No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry Bainbridge Naval Training Center Bainbridge, Maryland 15. Decedent's Education (Specify only highest grade completed) _Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles C. Jackson Ruth Cosner 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice W. Mains (Daughter) 858 Nesbitt Road, Colora, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Calvary Missionary 12/29/10 Rising Sun, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signature of Funeral Service Lice A. Patterson & Son Funeral Home, toll tran Maryland_ Perryville, 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final hysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Other (specify) 1 Yes 2 No signed by the a ld be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 iis certificate has been sig director, page 2 should t Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 2 🗶 No Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this nin 24 hours after death.

the Funeral Director: After this
inpleted filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide Investigation 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To previous of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the complex only one) 29b. Signature and title of certifier

Registrar

State

30. Name and

23a) (Type Pric

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bradford Lee Turner Medical December 2010 08:40AMM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1501 Carpenters Point Road Perryville Cecil Social Security Numbe **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Coundhester Pennsylvania 8. Date of Birth 170-44-9468 1**X** XM 2 □ F Months Days Hours Min. (Month, Day, Year Director Feb. Usual Residence of Decedent 28a-f show 10a. State 10b. County the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Cecil Perryville 1 ☐ Yes 2X No 10e, Street and Number 5 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 1501 Carpenters Point Road 21903 United States items death v 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, 1 Never Married 2 Married ò þ Black, White, etc. 1 XYes 2 No Army If Yes, Give 1986—87 Year or Dates. 72 hours after 21215-0036 1 ☐ Yes 2XX No Specify: "natural" 3 Widowed 4 Divorced Completed Specify White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Plumber Construction Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ဂ္ John Turner Ruth Caton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret E. Turner / Spouse 1501 Carpenters Point Road, Perryville, Maryland21903 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Delaware Veterans
Memorial Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State Januarv 4 ☐ Donation 5 ☐ Other (Specify) 2011 Bear, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Crouch Funeral Home South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death ectosigmoid disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Day Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 2X No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 \square Pending iniury 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗍 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and Mile of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

3

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9 per FH G911 1/11/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ogan, K, Tucker Day 17 Month 12 4:50 AM ຊ່ວ່າວ Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace Prifer Foreign 1**X** M 2 □ F Days Months Hours Min. (Month, Day, Year) 06-10-1949 550-78-3230 61 Director Dolaward Usual Residence of Decedent 10a State the Maryland 10h County 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f Delaware Sussex Seaford 1 Yes 2 XNo 10e. Street and Number 5 10f. Zip Code must be r 10g. Citizen of What Country? Funeral 22138 Shore Dr 19973 US items within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examiner 14. Race - American Indian, Armed Forces' ò δ 1 Never Married 2 Married Black, White, etc. 1 ☑ Yes 2 ☐ No 1969 If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Completed 3 Widowed 4 X Divorced Specify: White 1971 Year or Dates. 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) Sollege (1-4 or 5+) Electrician Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank Wilson Tucker Patricia Tisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Tucker - mother 22138 Shore Dr, Seaford, DE 19973 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Veterans Cem. DΕ 12/30/2010 Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur i Fun de Service densee 22. Name and Address of Facility Cranston Funeral Home Box 967, Seaford, 0 DE 19973 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final ysician/ Lactic 90190512 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, neı cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a sunsequel as of); -transit Exami executed resulting in death) Last Due to (or as a consequence of): burial-Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending physi IF FEMALE: be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ liver disease Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1X Natural (Month, Day, Year) 5 Pending ☐ Accident Investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attel within 24 hours after des To the Funeral Director completed filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signa re and title of certifier 29d. Date signed (Month, Day, Year) 1093030553 12/17/ M.O 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Quartraio 22 South Greens Street Baltimore, MO 21201 31. Date filed (Month, Day, Year) State 32. Pégistrar's Signature Registrar arks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20. Gertrude Catherine Voigt December 2010 03:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 155 North East Isles Drive North East Ceci1 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month Day Year)
April 22, **Funeral** 9 Birthplace (State or Foreign Soutth Orange 1926 New Jersey 1 ☐ M 2**XX**F Days Hours Director Yrs 148-12-2848 Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Ceci1 North East 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 155 North East Isles Drive 21901 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu one. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 9 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Peter Hector Catherine Hertling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia M. Markley/Daughter 155 North East Isles Drive, North East, Maryland 21901 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December North Tast Cemetery Methodist Cemetery K Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 27, 2010 North East, Maryland F meral Serv 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Myelo DYSPLASTIC disease or condition resulting in death) SYNDROME Medical Due to (or as a consequence of) Examiner GASTILO INTESTINAL BLEENING Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir signed by the attending physician and de detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed BREAST Cause (Disease or linjury CANCER that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 24 hours after death.

Funeral Director. After this certificate has eted filled in by the funeral director, page 2. autopsy Yes 2 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No ဂ္ဂ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2. Medical Examiner: On the basis of examination and/or investigation in my policies, death occurred at the cause(s) and manner as stated. Medical 29a. Certifier 2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mr

V. PULA,

29b. Signature and title of certifier

P.V. Naye N

NARATANA RAS

126

A E. HIGH

29c. License number

Dao 65733

STREET

29d. Date signed (Month. Dav. Year)

12/20/12

ELKTON, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month $12/2_{1/2010}^{Day}$ Physician/ Edison Franklin Williams 9:45a™ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Re Completed by Funeral Director Baltimore, Maryland 21215-0036

Physician/ Medical Examin

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

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	n yrs. last birthday)	If Under 1 Year If Under 1 Months Days Hours	er 24 Hrs. 8. Date of Birt Min. (Month, Date	h 9. Bi	rthplace (State or Foreign			
244-26-8129 ¹\\$\mathbb{Z}\ M 2 \Box F 82	Yrs.	World Says Hours	Min. 10/24/	1928	NC			
Usual Residence of Decedent								
	0c. City, Town or Loc				10d. Inside City Limits			
MD Calvert	Dunki	.rk			1 🗆 Yes 2 🔀 No			
10e. Street and Number	***	10f. Zip Code		10g. Citizen of What C	ountry?			
11615 Rivershore Drive		20754		U.S.A.				
11. Marital Status 12. Was Decedent Eve	er in U.S. 13. V	Vas Decedent of Hispanic C	rigin? (Specify Yes or No-	14. Race - Am	erican Indian.			
Armed Forces? 1 □ Never Married 2 □ Married 1 ☒ Yes 2 □ No	l If	Yes, specify Cuban, Mexic	an, Puerto Rican, etc.)	Black, Whi	te, etc.			
3 ☒ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1	Yes 2 No Specif	y:	Specify: W	hite			
15. Decedent's Education	16a. Deced	ent's Usual Occupation		16b. Kind of Business	s Industry			
(Specify only highest grade completed)	life DC	tind of work done during mo O NOT use retired)	ost of working		,			
Elementary/Seconday (0-12) College (1-4 or 5+)		eer Military		Airforce				
17. Father's Name (First, Middle, Last)			ther's Name (First, Middle,					
Nathaniel Williams			izabeth Watk	•				
	401				Va Cada)			
19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Num						
Deborah Bolton/Daughter		Shoreside P			· · · · · · · · · · · · · · · · · · ·			
20a. Method of Disposition 1 ☐xBurial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispos cemetery, crem	sition (Name of natory or other place)	Date	20c. Location - City of	r Iown, State			
4 Donation 5 Other (Specify)	Southern	Memorial Gdn	12/28/2010	Dunkirk,	MD			
21. Signature of Funeral Service Licensee		. Name and Address of Fac			lvert, P.A.			
Alsa M. Mounts	81	25 Southern						
23a. Part 1. Enter the disease, or complications that caused the					Approximate			
shock, or heart failure. List only one cause on each line. Immediate Cause (Final					Interval Between Onset and Death			
disease or condition	er car	ncer			years			
Due to (or as a c	onsequence of):				·			
Sequentially list conditions, b.					_			
if any, leading to immediate Due to (or as a cleaned cause. Enter Underlying	onsequence of):							
Cause (Disease or imjury								
resulting in death) Last Due to (or as a c	onsequence of):							
d								
IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of	pregnancy] =		23d. Date of d	elivery			
in the past 12 months? 1 Yes 2 No 4 Pregnant at ti		Ectopic pregnancy Other (specify)		Month	Day Year			
9 Unknown								
Part II. Other significant conditions contributing to death but	not resulting in the un	nderlying cause given in Pa	rt I. 23e. Did to	obacco use contribute t	to the cause of death?			
				Yes 2 X No 3 □	Probably 4 🗌 Unknown			
					14			
			24a. Was autor	osy prior to	utopsy findings available completion of cause of			
			perfo	rmed? death?				
25. Was case referred to medical		26. Place of De	eath (Check only one)					
examiner? 1 Yes 2 No Hospital:	t 2 ☐ ER/Outpatien	t 3 DOA Other: 4 D	Nursing Home 5 Kesic	dence 6 Other/Spe	cify)			
27. Manner of Death 28a. Date of injury	28b. Time of	28c. Injury at	1	now injury occurred	<i></i>			
1 Natural 5 ☐ Pending (Month, Day, Y	<i>(ear)</i> injury	work? M 1 ☐ Yes 2	_	, ,				
2 Activities Measurement of Could not be								
28e. Place of Injury - At home, farm, street, factory, office determined building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
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29a. Certifier 1 Certifying Physician: To the best of my (Check 2 Medical Examiner: On the basis of examiner)								
only one) 3 Certifying Nurse Practioner: To the be		leath occurred at the time, da	ate and place, and due to the	e cause(s) and manner a	s stated.			
29b. Signature and title of certifier		29c. License number		29d. Date signed (Mon	th, Day, Year)			
protest things		D0059	061	Decembe	121,2010			
30. Name and address of person who completed cause of dear	th (Item 23a) (Type, P	rint) Princ	061 e Fredenck					
ARATI PATEI IIN HOCK	to O Range	Suite 21		20678				
31. Date filed (Month, Day, Year) 32. Registrar's	Signature	,		00.0				
DEC 22 2010 Barres A	land del							
	STATE CALL TO STATE							

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ December Floyd Edward Wood 2010 12:01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days 12/16/1941 69 Missotri **Director** 493-48-9348 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director St. Leonard Maryland Calvert 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 20685 5265 Mackall Road 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, <u>გ</u> 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: 3 Divorced Completed d other than "nau." • the Medical E Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) construction concrete Be 17. Father's Name (First, Middle, Last)
Lloyd Rachel Wood, Sr. 18. Mother's Name (First, Middle, Maiden Surname, Nellie Viola Stevenson ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Marie Wood -spouse P.O. Box 200 St. Leonard, MD 20685 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Versailles Cemetery 1 NBurial 2 Cremation 3 N Removal from State 12/27/2010 Versailles Missouri 4 Donation 5 Other (Specify) of Funer I Service Licensee 22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Island Rd. Port Republic, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (spec/fy) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 s performed? Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 22 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Funeral Director: After completed filled in by the funer 1 🗷 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours at To the Funeral D Medical Lettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

Registrar

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31. Date filed (Month, Day, Year,

DEC 22 2010

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David Tardio, MD 110 Hospital Drive Prince Frederick MD 20678

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Albert Farl Wilkerson, Jr. Dec 22 2010 ay 4:50 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Calvert County Nursing Center Prince Frederick Calvert. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗖 M 2 🗆 F Hours 218-18-8999 09/9/12:/Proj22ar) Director Mary Tand Usual Residence of Decedent 28a-f show 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Calvert Prince Frederick 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 85 Hospital Road United States 20678 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1★ Yes 2 No.
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 🖵 Widowed 4 🗆 Divorced Specify: white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than " Elementary/Seognday (0-12) College (1-4 or 5+) boiler maker construction 1 and 2 should be filed w f Health and Mental Hygi item 27 is marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Farl Wilkerson, Sr. Lillian Novak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Beall - daughter 7838 C Street Chesapeaker Beach MD 20732 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Our Lady Star of the Sea 12/24/2010 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 5 4 ☐ Donation 5 ☐ Other (Specify) Solomons Maryland 21. Signature of Euneral Service License 22. Name and Address of Facility Rausch, Funeral Home 4405 Broomes Is, Rd. Fort Republic MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Enysician/ Atherosclerotic Medical resulting in death) Examiner Hypertensi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): as the burial-transit and Due to (or as a consequence of): signed by the attending physician To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Coronary Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed Advance Dementio 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No ျ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 🗌 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D. 50653 GYAN . C. SURANA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deale churchton 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

DEC 2 8 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month December 6:00 P M 2010 Physician/ WILSON, JR. JAMES Η. Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Prince George's Lanham 6413 Princess Garden Parkway 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 5. Social Security Number Elizabeth, NJ Months Days Hours **Funeral** 1 ☑ M 2 ☐ F 238-48-9161 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10h County be filed within 72 hours after death with the Maryland Director 1 √ Yes 2 ☐ No Lanham Prince George's MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20706 USA Funeral 6413 Princess Garden Parkway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give 1 Never Married 2 1 Married þ Specify: BLACK 1 ☐ Yes 2X No Specify. Baltimore, Maryland 21215-0036 Year or Dates 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation If item 27 is marked other than "nature or other traumatic event, the Medical 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Private Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha Assistant Pastor 18. Mother's Name (First, Middle, Maiden Sumame) Be 17. Father's Name (First, Middle, Last) ည Mary Arrington James H. Wilson, Sr. 1 and 2 should be of Health and Meritem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6413 Princess Garden Pkwy, Lanham, Maryland 20706 Lenora J. Wilson - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 12/22/2010 Brentwood, MD Ft Lincoln Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21, Signature of Funeral Service Licensee 20011 716 Kennedy Street, NW, Washington, DC 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARCINOMA OF THE PROSTATE WITH METASTASIS Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of) Medical Examiner Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE: 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23b. Was decedent pregnant Year Month Day in the past 12 months? Pregnant at time of death g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown filled in by the funeral director, page 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate has 1 Yes 2 No 2 X No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 X No 1 Yes မ 28d. Describe how injury occurred 28b. Time of 28c. Injury at 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 1 🙀 Natural 5 Pending 1 ☐ Yes 2 ☐ No М s after death. Accident Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 4 Homicide Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 24 hours Funeral Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c 1 icense numbe 29b. Signature and title of certifier

Registrar DHMH 17 Rev 7/2009

State

D37934

Trifoglio, MD, 7500 Greenway Center Drive, Greenbelt, Maryland 20770

ma

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephanie

12/20/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 24 2010 DECEMBER. SHIRLEY WEADON 12:07 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S 3508 EVANS MILLS COURT BOWIE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛚 Months Days Hours Min Yrs. T928 **Director** 181-22-5247 PITTSBURG, PA 82 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. It ment of Health and Mental Hyglene. It att. If flew 27, is marked other than "natural", or items 23a or 28a-f sho lury or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Ty Yes 2 No MD PRINCE GEORGE'S BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3508 EVANS MILL COURT 20716 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: BLACK Specify: Completed 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th SOCIAL WORKER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ EDWARD BUTTS CASSIE LEE PERRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANDRA WEADON/DAUGHTER 3508 EVANS MILL COURT BOWIE, MARYLAND 20716 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date 1 N Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) tery, crematory or other place) Removal from State MONONOGAHELA CEMETERY 1/3/2011 N. BRADDOCK, PA Inature of Funeral Service L 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each p the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death ₹hysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine nunsequente off cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) the attending physician ned for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) Day this certificate has been signed by the raid director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖺 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of prior to death? performed? 1 ☐ Yes 2 🕅 No 1 ☐ Yes 2 🗓 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 😾 No 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending X Natural nours after death. 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) D15512 2010 Kuman

State Registrar

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32. Registrar's Signature

5711 SARVIS AVENUE #200 RIVERDALE, MARYLAND 20737

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUSHAMA SREEKUMAR M.D.

2010

31. Date filed (Month, Day, Year)

DEC 3 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jason M. Wrightson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3 Time of Death Month Day December 22, 2010 **Medical Examiner** Jason M. Wrightson 1600 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 9702 47th Place Riverdale Prince George's 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of 8irth(MM/DD/YYYY) 9. 8irthplace (State or 7. Age (In yrs. last birthday) **Funeral** Foreign Country) Virginia Director Months Davs Hours 1[™]M 2□F 33 July 2, 1977 216 92 3358 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2XX No Upper Marlboro Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20772 7106 Aquinas Ave United States Funeral 11 Marital Status
1 Never Married 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 8lack, Armed Forces 2 Married White, etc. 2 XX No Yes 4 Divorced If Yes, Give Year White 1 Yes 2 No specify: 줊 15. Decedent's Education (Specify only highest grede completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than " Baltimore, MD 21215-0036 Landscaping Landscaper/Handyman of Health and Mental Hygiene.

If item 27 is marked other th 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Philip Glenn Wrightson, Jr. Peggy Jean Locantore Pages 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Wrightson (Mother) 7106 Aquinas Ave, Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State 1-6-2011 1 XX Burial 2 Cremation 3 Removal from State crematory or other place) Upper Marlboro, Maryland Brookfield Methodist Ch Cenetery 4 Donation 5 Other Specify 21. Signature of Full 22. Name and Address of Facility and Funeral home, Inc. 5033 CM Alexandria Ferry Road, Clinton, MD 20735 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and Medical Myocardial Fibrosis Death Immediate Cause (Final disease niner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examine Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED 23a,27 per me g912 2-25-11 vt X UNPENDED ending physician use as the burial Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? certificate h ector, page Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other4 Nursing Home 5 Residence 6 🗹 Other; Scene 2 ER/Outpatient 3 Inpatient this 1 Yes DOA After 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 X Natural 24 hours after death. I Director: d in by the f 5 Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) determined 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

Registrar

Assistant Medical Examiner 32. Registrar's Signature

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

December 23, 2010

30. Name and address of person who completed cause of death (Item 23a)

Signature and title of certifier

Donna M. Vincenti, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 28, 2010 **Physician** Jean Elizabeth Wolfe /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOGERSTOWN
If Under 1 Year | If Under 24 Lutheran Village avenwood If Under 24 Hrs. 8. Date of Birth (Month, Day, May 21 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** . 1926 Gapland, 1 □ M 2 🕱 F May Director 216-22-8114 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be rotified at 1ĂYes 2□No Director Hagerstown MD Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21740 1183 Luther Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 X If Yes, Give Year or Dates: 2**∑** No 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White <u></u> 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machine Shop 11 th Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Luella Ausherman ဂ္ John H. Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra 39 East Maple St., P.O.Box 563, Funkstown, MD 21734 Gary L. Wolfe / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 12/ 31/2010 Hagerstown, MD Rose Hill Cemetery 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licenses 305 N. Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 24 eaus **Physician** alrheen /Medical Due to (or as a consequence of): Examiner 50 days gasto ullsteril Sequentially list conditions, it are all the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of): Examiner law requires that the death certificate be executed burial-transi Ovonan and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 □ Yes 2 □ No 5 ☐ Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate ŽIŽ No 1 □Yes 2 No 1 ☐ Yes e Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

⊕H-1D State

DEC 2 9 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21 368 mill street-32. pegistrar's Signature Anna B. Sall

DHMH 17 Rev 1/2001

Registrar

Heigestown MD 21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 18 201 Pary Lee Walls 2:00P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Waldorf Center Nursing Home Waldorf Charles 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔀 F Days Jan. 8, 1916 Months Hours 94 Georgia Director 7373 241 72 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location Ħ 10a. State 10d. Inside City Limits Director notified MD Waldorf Charles 1 XYes 2 No 10e. Street and Number 10f. Zip Code .10g. Citizen of What Country? Examiner must be Funeral items 23a 1112 Harvard Road 20602 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2X No Black, White, etc. ģ 1 Never Married 2 Married "natural", or If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) 8th College (1-4 or 5+) Farmer/ Cook Private/Government Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James E. Robinson Lela McCormick permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Burnette McKinley/Daughter |1112 Harvard Road Waldorf,MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Carver Cemetery 12/28/201b Mt. Olive, NC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service bice see 22. Name and Address of Facility Briscoe-Tonic Funeral Home mbelly 2294 Old Washington Rd. Waldorf, MD 20601 23a. Fart 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner quantially list our difform Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L retail Co. 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 N Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1X Natural injury 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be 2 Accident
3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

2B5

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

State Registrar

DHMH 17 Rev 7/2009

who completed cause of death (Item 23a) (Type, Print)

12070

OUDLINE CENTER WALDENF, AND ZOGO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edmund 6:00P ^M Wilcox December 2010 Terrence Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 5830 Ripley Park La Plata Charles Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New Jersey 8. Date of Birth **Funeral** Min. (Month, Day September 1**X** M 2 □ F **Director** 048-16-8372 82 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5830 Ripley Park Road 20646 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 XMarried 1 ☐ Yes 2 XNo Specify: white Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important. If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Oceanographer/Geologist US Naval Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edmund Arnold Wilcox Mary Katherine Socha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Wilcox/Son 3457 Orange Grove Ct.,Ellicott Citv.MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Brinsfield-Echols Crem. 12/20/10 4 ☐ Donation 5 ☐ Other (Specify) Charlotte Hall,MD M00945 22. Name and Acquess of Facility of FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 20646 211_St. Mary's Ave. La Plata MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between THERO-SCLEROTIC Immediate Cause (Final HEAR Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ERTENSION 1 Tes 2 No 3 Probably 4 Unknown RENAL FAILURE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? STENOSIS performed? Yes 2 A No 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 A Residence 6 Other (Specify Hospital: 2X No 1 🗌 Yes ျင 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 5 Pending 1 Yes 2 No Investigation filled in by the Accident 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0026064 12-20-2010 10583-THEODORE GREEN BLY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

VIDYA SAGAR

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

MD

WHITE PLAINS, MD - 20695

ANMANGANDLA

32. Registrar's Signature

Funeral

Physician/ Medical Examiner

attending physician and for use as the burial-transit The law requires that the death certificate be executed Box 68760 Division of Vital Records,

For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $^{\text{Month}}_{12/16/2010}$ Year 9:19 David William White, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Frederick Calvert <u>Calvert Memorial Hospital</u> If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days Months 1 🗓 M 2 🗆 F 03/13/1952 Director 457-84-6477 58 TX Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director Owings 1 Yes 2 No Calvert MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20736 2050 Clearview Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 X Married by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Detective Law Enforcement e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other or other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David William White, Sr. Minnie Helen Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 si Department of Health a Important: If item 27 i any injury or other tra Vicki White / Wife 2050 Clearview Drive, Owings, MD 20736 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Southern Memorial Gardens 12/22/2010 Dunkirk, MD 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Signature of Funeral Service Licensee J. Coff Kary 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ocavar disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hypertens, that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed¹ death? 2 X No 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 No Other: 1 Yes မ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work 1 Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifie 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1742 732 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 28m 10 203. Dunkirk, Catherine Brophy, M.D., 10845 Town Center Dr., Ste. 31. Date filed (Month, Day, 32. Registrar's Signature State back Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Joseph Edward Wise 20 10 11:17 P M December 4a. Facility Name (if not institution, give street and number) c. County of Death
St. Mary's 4b. City, Town, or Location of Death Avenue 21230 Poplar Grove Lane 5. Social Security Number 8. Date of Birth *(Month, Day,* August 6, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Country)
Maryland Days Hours 1 🛛 M 2 🗆 F 218-34-6205 99 Yrs. 1911 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2X No St. Mary's Maryland Avenue 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20609 USA 21230 Poplar Grove Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: Specify. 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Tobacco Farm Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Marshall Wise Annie Victoria St. Clair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 331, Avenue, MD 20609 Mary Ann Williams / Duaghter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Bushwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Cemetery 30, 2010 21. Signature of Fuperal Service Lines Representation of the P.A. P.A. Box 270 Leonardtown, MD 20650 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PARKINGAY SUCOCIAF ADTERY

Physician Medical Examiner

Physician/

Medical

Director

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Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be marked once.

Baltimore, Maryland 21215-0036

the burial-trans

	resulting in death)	Due to (or as a consequence of):	The JEST	WASC		2001
ilcai Examiner	Sequentially list conditions, if any hading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):				
lysician/ivie	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Da	ay Year
ompieted by Fi	Part II. Other significant conditions con	tributing to death but not resulting in the und	lerlying cause given in Part I.		death?	oly 4 Unknown findings available letion of cause of
ט ע	25. Was case referred to medical		26. Place of Death (Che		140	
0	examiner? 1 ☐ Yes 2,XNo	ospital:	3 DOA Other: 4 Nursing	Home 5 Residence	6 Other (Specify)	
icare.	27. Manner of Death 1. Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury at work? M 1 Yes 2 No	28d. Describe how inju		
= 150 = 1	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street building, etc. (Specify)	, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Ro te)	ute Number,
ž		cian: To the best of my knowledge, death occ				(e) and manner state

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific.

Division of Vital Records, P.O. Box 68760

State Registrar 31. Date filed (Month, Day, Year) **DEC 28**

Bhasker Jhaveri, MD

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D33470

26840 Point Lookout Road, Leonardtown, Maryland 20650

29d. Date signed (Month, Day, Year) 12/27/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ erember RICHARD WASHINGTON Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death DOCTOR'S COMMUNITY HOSPITAL PRINCE GEORGE'S LANHAM 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 1 XM 2 - F Months Days Hours Min (Month, Day, Year) 12/10/1934 Wake Forest, Director 238-46-0441 76 Usual Residence of Decedent show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 28a-f 1 X Yes 2 No Marvland Prince George's Lanham 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8200 Good Luck Road 20706 USA items filed within 72 hours after death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. ò þ 1 🔽 Never Married 2 🗌 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give "natural" Completed 3 Widowed 4 Divorced Specify: Year or Dates BLACK the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Maryland State Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Highway Admin other traumatic event, Be 17. Father's Name (First, Middle, Last)unk 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked of ပ should be Josephine Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health ar tant: If item 27 is <u> Unita Williams / Daughter</u> 909 Comanche Drive Oxon Hill Maryland 20745 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or o cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Waldorf, Maryland 1/3/2011 Heritage Memorial 21. Signature of Funeral Service 22. Name and Address of Facility Pope Funeral Homes, P.A. MOIU <u>5538 Marlboro Pike Forestville, Maryland 20747</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin... térval Between Immediate Cause (Final Conset and Death Physician/ disease or condition resulting in death) Medical a comequence of Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury that initiated events that the death certificate be executed and -trans resulting in death) Last burialphysician Physician/Medical 37 Box 68760 the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day Year 2 No P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law certificate has autopsy death? performed? Yes 2 No Division of Vital 25. Was case referred examiner? sted filled in by the funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 X No မ 1 🗌 Yes 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death After t Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 🗷 Natural 5 Pending work? death. Accident Suicide Investigation 2 🗌 No within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

State Registrar only one)

DEC 2 9 2010

30. Name and address of person who completed caus

death (Item 23a) (Type, Print)

29c. License number

920

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dec 11 Physician/ Yeager Mary Frances 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Marlboro Castle of Love Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 XX Hours Min. (Month, Day, Year) Director 578 24 2843 86 Aug 8. 1924 Washington DC Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 No College Park Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20740 9209 48th Place United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14, Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give XX
Year or Dates. Black White etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3XXWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Payroll Clerk HEW Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary May Crawford Currin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth E. Yeager (Son) 9209 48th Place College Park, MD 20740 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Lee Crematory Dec 13, 2010 Clinton, Maryland 21. Signature of Funeral Ser 22. Name and Address of Facility Lee Funeral Hone, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ₹hysician/ disease or condition Medical resulting in death) Due Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ours after death. eral Director: After this certificate has I filled in by the funeral director, page 2 s autopsy death? 1 Yes 2 No 2. No Yes 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) Hospital 2**X** No 1 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu

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Registrar

31. Date filed (Month, Day, Year)

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ess of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

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Physiciar	1/	State Registrar 1. Decedent's Name (First, Middle Bernard	le, Last)		oaum	Cer	tificat	e of L	Death		2. Date of De	Reg. N	0.		3. Time of Death 8:40 AM M
Medica Examine	al	4a. Facility Name (if not institution	n, give street and nur						Location	of Death	Decemb	4	c. County	of Death	
Funeral		Friends Nursin 5. Social Security Number	6. Sex 1 1 1 M 2 □ F	_ ~	, ,	st birthday)	Sandy Spring Montgo					9. Birth	place (State or Foreign		
Director		578-18-3098 Usual Residence of Decedent			91	Yrs.					12/23/	1910			
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0 2.5	d by Funeral	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	If Alone Ci	orces? 2 🗌 ve	ever in U.S	TT 1	Vas Deced f Yes, spec	cify Cuba	ın, Mexicai	n, Puerto F	cify Yes or No Rican, etc.)	-	Blac	e - Americk, White,	
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exami	Completed		ent's Education lest grade completed)		16a. Deced (Give I life. De		rk done d	ation during mos	st of workir	ng	16b.	Kind of B		
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Mar 12 shou 11th and 27 is m		19a. Informant's Name/Relations Eleanor Appelb		2		1	•				l Route Numb				Code) r Spring MD
Baltimore, bermit. Page 1 and Department of Hee important: If item any injury or othe		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (3 X Removal from		Ce	ace of Dispo emetery, cren ional	natory or c	ther plac	ce)	L)ate /2010	200.	Location	Oity Of 1	own, State 20906 ch, VA
Balti permit. Departit Importa any inju		21. Signature of Funeral Service	Liconsee	м0	1163	22	Earwar 109	d Addre	ss of Facili age 1 ckvi1	Fune	ral Di	rect kvi	ion ile i	Inc MD 20	0852
Ph_sician/ Medical Examiner	7.5	23a. Part 1. Enter the disease, c shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on e	ach line eumo	I the death onia a consequ	. Do not ente									Approximate Interval Between Onset and Death
executed an and rial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С		a consequ a consequ										
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate be 124 hours after death. Funeral Director: After this certificate has been signed by the attending physicis ated filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Birth gnant a	of pregnar 2 Fetal t time of d	death 3	Ectopic Other (s)		су					te of deliventh	very Day Year
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Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Certificate:	3 Suicide 6 Could	not be 28e. Plac		ury - At hor c. (Specify)	me, farm, str	eet, factor	y, office			28f. Location City or To			er or Rura	al Route Number,
ne Hospit n 24 hour ne Funera pleted fille	Medical	(Check 2 Medical	g Physician: To the Examiner: On the bag Nurse Practioner	sis of e	xamination	and/or invest	tigation, in	my opinie	on, death o	occurred at	the time, date	and place	ce, and du	e to the ca	ause(s) and manner stated.
To the within 2 To the comple	_	29b. Signature and title of certific		N	m	Mu		D357	e number 91				-		Day, Year) 2011
10		30. Name and address of person Merlyn Vemury,	who completed cau	se of d	eath (Iter	28a) (Type, F Avenue	#22	7 Si	lver	Spri	ng MD 2	2090	2		
State Registra		31. Date filed (Month, Day, Year)	_		_	1. ba									

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1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy this certificate has perform death? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Natural 5 Pending 1 Yes 2 No Investigation Accident 24 hours after death Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide determined Medical Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Louis Michael Apostolakos 010 7.101M 2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Friends Nursing Home Sandy Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Sex 1 M 2 □ F Funeral Months Days Hours Min. May 22. Washington. 578-18-9539 88 Director Usual Residence of Decedent or 28a-f shov 10b. County 10a, State 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Funeral Director 1 Yes 2 X No Silver Spring Maruland Montaomeru 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 U.S.A. 15101 Interlachen Drive. Apt. #107 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. rmed Forces? Black White etc. ģ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced WWII White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ni
any injury or other traumatic event ** (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Entrepreneur Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Michael Apostolakos Mary Christakos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7429 Old Washington Road. Woodbine, Maryland 21797 Nancy A. Hancock - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 12/23/2010 | Rockville, Maryland Parklawn Mem. Park 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinulli Funeral Home, Mo #1070 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final EUMONIA Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) has been signed by the attending physician ge 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 L Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by LMONARU ASTRUCTIVE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performed 1 ☐ Yes 2 ☑ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No 힏 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manny of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director; After injury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) 12 285 10 110020 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE SUITE 203 BACIOMI 8miTH SNEEM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Clara F. Adkins Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number **Examiner** sbun omic if Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 12/09/1943 1 🗆 M 2 🏻 F Maryland 67 212-40-8862 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No Salisbury Wicomico Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 USA 300 Pond Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. ģ 1 X Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Specify: white Completed 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ healthcare nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Nettie Shockley Earl Adkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 300 Pond St., Salisbury, MD 21804 Kelley Douglas/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Salisbury Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 12/22/2010 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ CHRONIC resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (ur as a consequence ui) Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Month Year 4 Pregnant a Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 X No 1 Yes ည Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) EASTEAN SHORE DR. SALISBURY MD21804 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death December 14 Physician/ 2010 6:18 p M Ronald Wayne Bryan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester 605 Edlon Park Cambridge 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Marry land 217-42-5290 Director Usual Residence of Decedent items 23a or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location Director MD Dorchester Cambridge 1 X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 605 Edlon Park 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 A Yes 2 Black White etc. 1 Never Married 2 Married ð Maryland 21215-0036 If Yes, Give 1962-66 Year or Dates. white 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) machinist electric company Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Rachael Beckwith Ronald Weldon Bryan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carol Bryan wife 605 Edlon Park, Cambridge, MD 21613 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State East New Market Cem. 12/18/10 East New Market, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. tore of Funeral Service Licen-700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. month S Immediate Cause (Final ependumoma - Brain Cancer anaplastic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 performed 1 Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in rriy opinion, usual recurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d, Date signed (Month, Day, Year) heckar. 29c. License number H68413 D. S. Fassett Magee CHC 503A Mur ST 31. Date filed (M State Registrar

State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Physician/ Bah Adiatu 1900 Haja Dec. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Montgomery Takoma Park 9. Birthplace State or Foreign Leone Sierra If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days Hours Min. (Month, Day, Year) 1935 1 □ M 2 🛛 F Director 138-04-5416 75 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No Laurel MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20708 Sierra Leone 14607 Bowie RD, Apt. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 X Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry Ukn (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) UKn • College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chernor Amadu Bah Fatmata Bah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ibrahim Bah/Son 14607 Bowie Rd. #202 LAurel, MD 20708 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Maryland National Dec. 11 4 Donation 5 Other (Specify) Laurel Maryland 22. Name and Address of Facility Latney's Funeral Home 21. Signature of Funeral Service Licensee cc278 Wash. D.C.20011 3831 Georgia Ave., N.W. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DSIS 0 Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last physician a sthe burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 Aho 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed' 2 🗆 No 1 🗌 Yes Yes 24 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. Be Hospital 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 욘 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending safter death.

I Director: Aff d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0060100 1209-10 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AHMINA BLVD Eail SILVESIA University 31. Date filed (Month, Day, Year) 32. Registrar's Signature State UEC 28 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - Unit U 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 24 Physician/ 5:30p M Fannie Blaik 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Silver Spring Montgomery 14400 Homecrest Road, Apt. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral New York 1 □ M 2 🕱 F Months Days Hours Min. (Month, Day,) UNE. 14 Year) Director 122-14-0337 June Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director 1 Yes 2 No Silver Spring Maruland Montaomeru 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 U.S.A. 14400 Homecrest Road, Apt. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces? Black White etc "natural", or i þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗶 No Specify: White. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Prince George's County life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Public Schools Math Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 7 is marked o ပ Anna Maijer Henry Dickler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a MD20906 Apt. #102, Silver Spring, 14400 Homecrest Rd.. Maurice Blaik - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If its any injury or ot 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State Judean Memorial Grdns: 12/27/2010 Olney. Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Onset and Death Immediate Cause (Final Physician/ Coronary Artery Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 X No Day Year Pregnant at time of death 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cardiac Arrhythmia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No 1 Yes Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Assisted examiner? Hospital 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 2 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? X Natural injury 5 Pending thin 24 hours after death.

the Funeral Director: Af
impleted filled in by the fu 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner. On the basis of examination already involgation, and year and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 ►To the F 29b. Signature and title of certifier 063999 12-25-2010 MO Motur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18111 Prince Philip Drive, Suite 101, Olney, Maryland 20832 Ata Motamedi, M.D., 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year 2010 December 9, 12:17 Marion Lee Brown, Sr. 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center Wicomico Salisbury If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Min. Months Days Hours 68 216-40-4461 August 5, 1942 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 21 No Salisbury Maryland | Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1527 Esquire Drive 21801 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married Specify: Black 1 ☐Yes 2 🗓 No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Wicomico County Board Elementary/Secondary (0-12) College (1-4or 5+) 12th custodian of Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arthur Leroy Brown, Sr. Hazel Louise Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maxine Brown/daughter 207 Hollowmist Drive - Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Zion U. M. Cemetery 12/18/2010 Mardela Springs, MD 4 ☐ Donation 5 ☐ Other (Specify) f Funeral Service Licenses 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD JOLLEY MEMORIAL CHAPEL 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final IENS101 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Course Office or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Ye ar 5 Other (specify) 1 Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2¶ No 1 □Yes 2 🗷 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be

Examiner Physiclan: The law requires that the death certificate be executed and burial-tra Division of Vital Records, P.O. Box 68760, attending physician for use as the buria the 1 as use s been signed be should be deta page 2

Physician/Medical Examiner

à

Completed

Be

Certification: To

Medical

(Check only one)

Physician

Examiner

Funeral

Director

r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at

Funeral Director

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Completed

Be

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the Maryland

filed within 72 hours after death with Hygiene.

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If Item 27 is marked other the any Injury or other traumatic event, Italiano.

Physician

/Medical

Maryland 21215-0036

Baltimore,

/Medical

certificate | After this or Attending To the Hospital or Attendity within 24 hours after death.
To the Funeral Director: A completely filled in by the fu

25. Was case referred to medical 27. Manner of Death 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 60515

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mahesha Thimmarayappa 910 Eastern Shore Drive - Salisbury, Maryland 21804

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 8:15 A **RUTH PAULINE ADKINS BRADFORD** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MALLARD BAY CARE CENTER CAMBRIDGE DORCHESTER 8. Date of Birth 1910 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** (Month, Day, Year) 6/15/2010 Country) MARYLAND Days 1 □ M 2 🔀 F Months Director 214-07-9956 100 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at Director 28a-f 1 X Yes 2 No **MARYLAND** DORCHESTER **CAMBRIDGE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ٥ 23a Funeral 21613 215 KILLARNEY RD items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. Ö ģ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: "natural" Completed 3 X Widowed 4 □ Divorced WHITE Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) **SEAMSTRESS** CLOTHING 12 Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ತ್ತ MARY FRANCES LANKFORD SAMUEL HOOPER ADKINS . Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 30837 RIVER RD., LAUREL, DE 19956 ROLLAND E. VINCENT, JR. / COUSIN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State EAST NEW MARKET, MD 4 Donation 5 Other (Specify) EAST NEW MARKET CEMETERY 12/30/2010 Signature of Funeral Service Lie 22. Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. cardiovaccular diferen Arteriosclente Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 2 🗆 No 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 CN 2 4 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to Be Was case referred to medical 26. Place of Death (Check only one) Other: 2 HNo ည 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending 1 Aatural 1 ☐ Yes 2 ☐ No 2 Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 503

32. Registrar's Signature

BYRN

CAMBRIDGE MD 2613

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 13 2011

THANWY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 1:30 A M 2010 Dec. Robert James Briddell 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Salisbury Wicomico 1107 Middleneck Drive 8. Date of Birth (Month, Day,) April 13, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) Year) 1933 Hours Min. 1₫M 2□F Months Days Maryland 220-28-0965 77 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Wicomico Salisbury Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 1107 Middleneck Drive 21804 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 【XNo 11. Marital Status Black, White, etc 1 ☐ Never Married 2 Married 1 Tyes 2 No. If Yes, Give Year or Dates Specify: Black Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Mill 7th laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Spencer Briddell, Sr. Ella Mae Fassett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1107 Middleneck Drive - Salisbury, MD 21804 Laverne Briddell/spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Acres Mem. Pk | 12/31/2010 | Salisbury, Maryland 22. Name and Address of Facility $1213\,$ Jersey Road, Salisbury, MD 21. Sign fur of Funeral Service Licens JOLLEY MEMORIAL CHAPEL 21801 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final U disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death (Month, Day, Year)

Examine the death certificate be executed attending physician and for use as the burial-transi Box 68760. Physician/Medical signed by the a P.O. I of Vital Records, þ Completed The law this certificate has Be 2 Division

Physician

Examiner

Funeral

Director

show

Director

Funeral

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Completed

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2 should be filed within 72 hours after death with the Maryla nand Mental Hygiene. Its marked other than "natural", or items 23a or 28a-f show its marked other than "natural", or items 23a or 28a-f show raumatic event, its "worked Examine must be northed."

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event

Physician

/Medical **Examiner**

Saltimore, Maryland 21215-0036

the Maryland

/Medical

Hospital or Attending Physician; eral Director: After the filled in by the funeral death. after 24 hours a

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Certification: 1 Matural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical npletely and manner stated. the the 29d. Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certifier VU5 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 East Carroll Street, Salisbury, Maryland 21801

Joseph Α. Grasso, M.D.

31. Date filed (Month, Day, Year)



2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylan				and Mental H	,	711111	12528	
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of	Deam	2. Date of D	Reg. No.	- 0 1 0	3. Time of Death	
	Physicia Media		LILI	IE BELLE	BURROU	GHS		Decem		2, 2010	3:28 рм	
4	Examir		4a. Facility Name (If not institution, give str Ft. Washington Heal		Center	4b. City, Town, Ft. Wa	or Location on a shingt			County of Death ince Geo	rge's	
	Funeral Director		5. Social Security Number 6. Sex $578 - 28 - 4817$	M 2 X F 7. Age (In yrs. le		If Under 1 Year Months Day			Day Vacal	9. Birthp Coun 921 Sout	olace (State or Foreign try) Carolina	
	rland f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge		y, Town or Loc mple	ation Hills				1	0d. Inside City Limits	
	the Mary or 28a- oe notifie	I Director	10e. Street and Number			10f. Zip Code	0748			izen of What Coun	1 ☑ Yes 2 ☐ No try?	
	eath with tems 23a er must t	-unera	4706 Tamworth 11. Marital Status 1:	2. Was Decedent Ever in U.S	S. 13. V	Vas Decedent of	Hispanic Orig	in? (Specify Yes or N		USA 14. Race - Americ		
9000	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner.	Completed by Funeral	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Yes, specify Cu		, Puerto Rican, etc.)		Black, White, 6		
1215-(thin 72 hou ene. than "nat he Medica	Somple	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)		(Give k life. D	ent's Usual Occi ind of work don NOT use retire Servic	e during most d)			nd of Business Ind vernment		
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last) £11iott W.	Pr	essley			er's Name (First, Midd)		Sumame)	ington	
	and 2 should Health and M tem 27 is mai		19a. Informant's Name/Relationship (Type James E. Burrou		19b. Mailin 4706	g Address (Stree Tamwo:	et and Numbe rth Ct	r or Rural Route Number . , Temple	ber, City or Hills	Town, State, Zip C , MD 207	60de) 48	
Baltimore,	Page 1 and ment of Hea ant: If item ary or othe		20a. Method of Disposition 1 □X Burial 2 □ Cremation 3 □ Ro 4 □ Donation 5 □ Other (Specify)	moval from State		sition (Name of patory or other pa	ace)	Date 2/29/2010		ecation - City or To		
Balti	permit. Page Department Important: I any injury o		21. Signature of Funeral Cervine Licensee	Ata				Jordan F d.,N.E., W				
1	Physician/		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the death cause on each line. Congestiv				cardiac or respiratory	arrest,	7	Approximate Interval Between Onset and Death In r S	
-	Medical Examiner		resulting in death) a.	Due to (or as a consequ Ischemic	ience of):						2 yrs	
	ted 1	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequ Hypertens							5 yrs	
0	ate be executed physician and the burial-transit	cal Ex	that initiated events c. resulting in death) Last	Due to (or as a consequ	ience of):							
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. Box 687	e death certificate be executed the attending physician and thed for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	c. If yes, outcome of pregnar 1 Live Birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3	Ectopic pregna Other (specify)	ncy			23d. Date of delive Month	ery Day Year	
s, P.O.	Attending Physician: The law requires that the dea car dath. ector Heath: ector Heath is certificate has been signed by the a y the funeral director, page 2 should be detached I		Part II. Other significant conditions conti	ibuting to death but not resu	ulting in the u	nderlying cause	given in Part I	1		se contribute to th	e cause of death?	
ecord	e law require e has been si ge 2 should b	Completed by								24a. Was an autopsy performed? 24b. Were autopsy findings av prior to completion of cau death?		
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n of	ding Phys h. After this funeral di		27. Manner of Death 1 Ⅺ Natural 5 ☐ Pending		28b. Time of injury	28c. Inj	ury at ork?	28d, Describe				
Division of Vital Records,	al or Atten s after deat I Director: d in by the	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and City or Town, State)						Route Number,	
_	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director, After this completed filled in by the funeral di	Medical ((Check 2 Medical Examine)	an: To the best of my knowle : On the basis of examination Practioner: To the best of my	and/or investi	gation, in my opi	nion, death oc	curred at the time, date	and place,	and due to the cau	ise(s) and manner stated	
	Vith To th		29b. Signature and title of contifier	A A			se number			e signed (Month, L		
Š			30. Name and address of person who com	pleted cause of death (Item	23a) (Type, P		-2453!)	рес	emper :	27, 2010	
R	3		Laxmi N. Berwa	MD 7700 B:	ranch		Clint	ton,MD	20735	Suit	e C101	
	Stat	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure							

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Broome who over 8,'45 AM 2010 Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 I F MAY 1919 91 MARYEAND Director 577-20-5368 Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Junyon cant: If item 27 is marked other than "natural", or items 23a or 28a-f sho arrive in y or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits PRINCE GEORGE'S 1 X Yes 2 No MD LANDOVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3702 64th AVENUE 20785 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 2 No ARMY Baltimore, Maryland 21215-0036 BLACK 1 Yes 2 No Specify: If Yes, Give 3 X Widowed 4 □ Divorced Specify. Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1YR POLICEMAN GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ PHILIP M. BROOME CAROLYN WHEELER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBORAH MCNEIL/DAUGHTER 9706 BUTTERFLY LANE SPRINGDALE, MARYLAND 20774 mpocant: If item any injery or off 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) MD NATIONAL CEME. 12/29/2010 LAUREL, MARYLAND Signature of Fund al Savice Licer J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner mondey Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) hysician and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed NOXI' a that initiated events Due to r s a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year the 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Director: After this certificate has been signed by it in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 ☐ Yes 2 🔀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🔀 No 1 🔲 Yes Other: မြ 1

Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined after 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0069669 Jama 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANUPAMA NEELAKANTA M.D. 3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 31. Date filed (Month, Da 32. Regultrar's Sangtur State 8 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 2010 3:00 АМ Ernestine Frances Blowe Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Center Clinton Date of band (Month, Day, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 53 Director 579-92-3283 Sept. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Director 1 X Yes 2 No Suitland Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral #202 4419 Rena Road 20746 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 11. Marital Status ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Private Homemaker 12th Be permit. Page 1 and 2 should be filed.
Department of Health and Mental H.
Important: If item 27 is marked ott
any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Laura Ann White Richard Cephas Blouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20746 4419 Rena Road # 202 Suitland, Maryland Gwendolyn B. Marrow - Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State January 2011 4 Donation 5 Other (Specify) Lincoln Memorial Suitland, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Stewart Funeral Home, Inc. 20019 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Approximate Interval actween On a Death shock or yeart failure. List only one cause on ear Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a construence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a cor physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): this certificate has been signed by the attending physician al director, page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No 1 Inpatient Certificate: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After thi filled in by the funeral 27. Mann Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending Natural 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) To the Hospital within 24 hours a To the Funeral C completed filled Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of contifier 29b. Signatur 29d. Date signed (Month, Day, Year) 29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HVe

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Burnell Physician/ Shirley Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wic omic 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday Social Security Number 6. Sex **Funeral** 1 🗆 M 2 🏋 F Months 12/04/1934 Missouri 422-42-6134 Director 76 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 X No Maryland Wicomico Parsonsburg 10f, Zip Code 10e. Street and Number 10g, Citizen of What Country? 23a Funeral USA 21849 7494 Walston Switch Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ٥ 1 Never Married 2 Married ò 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates white permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) domestic homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lela Belle Stallings Medicus Inzer Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Maijing Address (Street and Number or Bural Route Number. City or Town, State, Zip Code) 21849 7494 Walston Switch Rd., Parsonsburg, MD Gerald Burnell/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Eastern eshore to fac MD any injury or 12/22/2010 Hurlock, MD Veterans Cemetery 21. Signature of Funeral Service Licensee 22 Name and Address of Facility al Home Professional Association Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immedi-cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Pregnant at time of death ò signed b I be deta Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one) 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) TERN SHORE DR, SALISBURY MD 21804 31. Date filed (Month, Day, Year) State 29 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Baker Fountain Henry 2010 10:15 A December Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Wicomico Wicomico Nursing Home Salisbury 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min 219-05-9172 Director 08/06/1920 Maryland 90 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County Director Salisbury 1 X Yes 2 No Wicomico Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21804 316 East Vine Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important, If Item 27 is marked other than "nature" any injury or other treasments. 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give AirForce 1 ☐ Yes 2X No Specify: white 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) truck driver trucking Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ပ Mary Cook Harry Baker 19a. Informant's Name/Relationship (Type, Print)
Sally Baker/spouse 19b Mailing Address (Street and Number of Rural Route Number, City of Town State, Zip Code) 316 E. Vine St., Salisbury, MD 21804 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 12/22/2010 Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune Service Licenses Holloway Funeral Home Professional Ass 501 Snow Hill Rd., Salisbury, MD 21804 Association 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PMENTI Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav 5 Other (specify) Pregnant at time of death the cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital Other: 1 \(\text{Yes} \) 2 Z No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 \square Pending 2 🗌 No Investigation filled in by the Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Sulciue 4 ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

only one) 29b. Signature and title of certifie

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mahesha Thimmarayappa

M.D.

enera

egistrar's Signature

29c. License number

910 Easternshore Dr Salisbury MD 21804

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^D19, <u>2010</u> Bakalik Margaret December 11:35 pM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 839 Johnson Road Salisbury Wicomico Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 🗆 M 2 🍱 F Days Hours 212-22-6244 84 0971271926 Director Maryland Usual Residence of Decedent 28a-f show artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho: injury or other traumatic event, the Medi-al Examiner must be notified at. 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🏝 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 839 Johnson Road 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black White etc. 1 Never Married 2 Married Completed by ☐ Yes 2 🗙 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: If Yes, Give 3 X Widowed 4 Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) housewife domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stephen Krus Agnes Spochacz 19a. Informant's Name/Relationship (Type, Print)
Kathleen Michalski/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is 839 Johnson Rd., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 12/21/2010 Salisbury, MD 21. Signature of Funeral Service License Holloway Fufferal Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Procressive DEMENTIA Medical resulting in death) Due to (or as a consequence of) Examiner Atheroscie Rotic VESSEL DISEASE Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence of sician and burial-transit death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 No signed by the a 9 Unknown that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC KIDNEY DISEASE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown DEGENERATIVE JOINT DISEASE 24a. Was an Were autopsy findings available prior to completion of cause of page Hospital or Attending Physician: The L24 hours after death. Funeral Director: After this certificate hated filled in by the funeral director, page performed? death? 2 🗌 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 XNo ျှ 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours a To the Funeral D Medical 12 Sectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D36576 and address of person who completed cause of death (Item 23a) (Type, Print) DR. SALISBURY NO 2809 1665 WOODBROOKE MO 1124017E 32 Registrar's Signature State reun Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year PM 951 Ceres a Rosethel -2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Trauna Baltimore Center Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 F Hours Months Min. July 25, 1935 187-26-9994 75 Pennsylvania Director Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location "natural", or items 23a or 28a-f sho 10d. Inside City Limits Director Prince George's College Park Maryland 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9606 Rhode Island Avenue 20740 United States hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò 1 Never Married 2 X Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify Completed 3 Widowed 4 Divorced er than "natur , the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Business Manager Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) it. Page 1 and 2 should be froment of Health and Menta rtant: If item 27 is marked njury or other traumatic en ည Patrick F. Comer Celestine Weber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard D. Ceresa, Jr. -husband 9606 Rhode Island Avenue College Park, MD 20740 Baltimore, 20a. Method of Disposition
1 💆 Burial 2 🔲 Cremation 3 🗍 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or ot Fort Lincoln Cemetery 11/3/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee Bonald Vores Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ loxic Migacolon disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Clostridian Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to lor as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Day 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COPD Preumonia, rib fractures Completed 1 Yes 2 No 3 Probably 4 Unknown chronic renal insufficiency, Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? fractures . hlo lung A-fibi Pelvic this certificate RVR. cancel 1 Yes 2 No ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 211 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Subject vatural 1 Natural
2 Accident 5 Pending 4:39 a M passenger in a car collided 10/23/2010 1 ☐ Yes 2 XNo Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Greenbelt Road at 4 - Homicide determined Roadway Frankfort Dr., Greenbelt, MD To the Hospital within 24 hours a To the Funeral C completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 20a Certifier 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month. Day, Year) AU4176435N18922 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Nadran Street BallingereMI 31. Date filed (Mon)/ Da State Registrar

Registrar

IAN 1 3 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 20b per fh,g911,01/13/2011dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JOHN VINCENT CUDDY 2010 11:30 A^M DEC Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 X M 2 🗆 Months Days Hours Min. (Month, Day, Year) 047-281540 **Director** 73 Feb. 1937 Connecticut Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits Director 1 🛚 Yes 2 🗆 No VA Loudoun Lovettsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11884 Ropp Lane 20180 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ģ 1 🔀 Yes 2 □ No If Yes, Give 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired third of Einance and Medicine (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Government Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Harold Cuddy Margaret McAghallan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Cuddy - Wife 11884 Ropp Lane, Lovettsville, VA 20180 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 03/1972011 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington Nat'l Cemetery Unk Arlington, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Colonial Funeral Home 201 Edwards Ferry Road, NE, Leesburg, VA 20176 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death PULMONARY VESSEL HEMORRHAGE disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 9 Unknown Be Completed by ဂ္

Physician/ Medical Examiner that the death certificate be executed and-tran attending physician a for use as the burial-Box 68760 ed by the a P.O.

an "natural", or items 23a or 28a-f show Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

hould be filed within 72 hc and Mental Hygiene. s marked other than "na

Should be file and Mental H

permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau

other traumatic event, the

yithin 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral Certificate: Medical

has been signed e 2 should be del

certificate

Records,

Division of Vital

Part II. Other significant condit	ons contributing to death b	out not resulting in the ur	nderlyin	g cause given in Part I.		se contribute to the cause of death? \mathbf{X} No $3 \square$ Probably $4 \square$ Unknow		
					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No		
25. Was case referred to medica examiner?		26. Place of Death (Check only one)						
1 Yes 2 No	Hospital: 1 ☒ Inpati	ome 5 Residence 6 Other (Specify)						
	igation		М	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury			
3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	200 Place of Init	ury - At home, farm, stre	et, facto	28f. Location (Street and City or Town, State)	28f. Location (Street and Number or Rural Route Number, City or Town, State)			

1定 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) Dec, 2010

01055104A (IN)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LCDR

NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

BAYDARIAN 31. Date filed (Month, Day, Year) State

29a. Certifier

13

32. Segistrar's Signature

USN

MC

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month DEC $16^{\text{Day}}2010$ KATHARINE CLAYTON CRITTENBERGER 5:45 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY Birthplace (State or Foreign Country)
_____ Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8 Date of Birth 7. Age (In vrs. last birthday **Funeral** Days Min 1 M 2 K F (Month, Day, Year) 03/06/1926 Director 511-34-2737 84 Texas Usual Residence of Decedent if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matter at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6200 Oregon Ave NW # 208 20015 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Philip Coleman Clayton Carol Clough 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willis Dale Crittenberger Jr 6200 Oregon Ave NW # 208 Washington DC 20015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 3/7/2011 Arlington Nat'l Cem. Arlington, Va 22. Name and Address of Facility Joseph Gawler's Sons 21. Signature of Funeral Service License 5130 Wisconsin Ave NW Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition CONGESTIVE HEART FAILURE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Year Pregnant at time of death 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 2 No Yes 2 X No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other 1 Yes 2 X No ျ 1 A Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sionature and title 29c. License number

State Registrar raylar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CDR

MC

USN

32. Registrar's Signature

PASIUK

BRET N.

Date filed (Month, Day, Year)

DEC

D0065200

12,17,2010

CENTER

NATIONAL NAVAL MEDICAL

BETHESDA MD 20889-5600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6:55 PM MARIA COEHLO DEC 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY ROCKVILLE HEBREW HOME 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** JUNE I, 1906 1 □ M 2 🏋 F Months Days BRĂZTI. Yrs Director 225-58-2115 104 Usual Residence of Decedent 28a-f shov 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 1 Y Yes 2 □ No MONTGOMERY MD. ROCKVILLE 10e. Street and Numbe 10g, Citizen of What Country? Funeral 6121 MONTROSE RD 20852 BRAZIL 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. <u>8</u> 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give altimore, Maryland 21215-0036 1 X Yes 2 ☐ No Specify: 3 √ Widowed 4 □ Divorced Completed Specify: BRAZILIAN WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOUSEWIFE HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNK. UNK. ပ္ t. Page 1 and 2 should b tment of Health and Mer rant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other the WILLIAM CARTER/FRIEND 3917 LARO CT., FAIRFAX, VA. 22031 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS 12-22-2010 CREMATORY RIVERDALE, MD. 21. Signature of Funeral Service Licensee Name and Address of Facility HOME & CREMATORIUM, P.A. M00091 CLEVELAND AVE., RIVERDALE, MD. 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Advanced Demontio Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Box in the past 12 months? Month Day Year Pregnant at time of death been signed by the a should be detached f g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a. Was an autopsy perform Yes 2 X No of Vital Hospital or Attending Physician: 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending Division Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12-22-2010 D006487 Forze 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6105 Montrose MD Fuzli

Registrar

State

31. Date filed (Month, Day, Year,

10-10119 Keith Thomas C		nan S 1-For State	pe or Print i tate of Maryla	and / Depa	delible In rtment of tificate of	Health and	All Cop Mental	ies Are L Hygiene		Sugar No.	0	42539
Physicia	_	Registrar 1. Decedent's Name (First, Midd	ile,Last)		imouto o.		 -	2. Date of D			3.	Time of Death
Medical Exami		Keith Thomas C	oleman					Month Decemb	per 30,	2010 Year		1657 hrs
		4a. Facility Name (if not instituti 188861 McFarlin Driv	on, give street and n	umber)	4	ath	4c. County of Dea Montgomery					
Funeral	-	5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24H	Irs. 8. Date of	Birth (MM	/DD/YYYY)	9. Birthp	lace (State or
Director		215-76-1379	1XM 2F	5	1 Yrs.	Months Days	Hours M	lin. Oct	22,	1959	Foreign Count	D.C.
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ith the Maryland 23a or 28a-f show	Director	10e. Street and Number	-			10f. Zip Code				tizen of Wha		
with the ns 23a c		18861 McFarli 11. Marital Status	12. Was De	cedent Ever in U.S		20874 Decedent of Hisp					American	Indian, Black,
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or Items 23a or 28a-f she rent, the Medical Examiner must be notified at once	by Funeral		Married Armed F 1 Yes Vorced If Yes, Give Ye or Dates:	2 X No		s, specify Cuban, Yes 2 X No	,	rto Rican, etc.)		White,	Whit	:e
2 hours		15. Decedent's Education (Spe Elementary/Secondary (0-12)	ecify only highest gra	de completed)		's Usual Occupation of working life. I			16b.	Kind of Bus	iness/Indu	ustry
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215-0 e filed v tal Hygi ced other	Be Co	17. Father's Name (First, Middle Thomas W. Col				11		me (First, Middle M. Cole		n Surname)		
MD 21215-0036 11 should be filed within 7 12 should be filed within 7 127 is marked other than umaric event, the Medica	P	19a. Informant's Name/Relation	ship (Type, Print)			Address (Street	and Number o	r Rural Route N	Number, C		, State, Zi	p Code)
6 78 78 78	1	Kevin Coleman/ 20a Method of Disposition			lace of Disposi	BOX 45170		Date Date	743 20c.	Location -	City or To	wn, State
Baltimore, permit. Pages I an Department of He important: If ite		1 Burial 2 X Crematio 4 Donation 5 Other S	_	OIII State	rematory or oth antic C	rematory	1,	17/201	/ G1	en Bu	rnie,	MD
Balti permit. Departr Import injury		21. Signature of Funeral Service	Licensee	моо		ame and Address of Park Ave						rice,p.a.
Physician Medical		23a. Part I. Exter the disease, o failure. List only one cause	on each line.	caused the death.	Do not enter th	e mode of dying, s	uch as cardiad	or respiratory	arrest, sh	ock, or hea	rt /	Approximate Interval Between Onset and Death
≛xaminer		Immediate Cause (Final disease or condition resulting in death)		a consequence of)		ITOVASCUI	at Dis	ease				
	liner	Sequentially list conditions, if any, leading to immediate cause. Finer Underlying Cause		a consequence of)):						230	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exequirin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician an completely filled in by the funeral director, page 2 should be detached for use as the burial—in	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Un	he 1 Live	nant at time of dea	2 Feta	er (Specify)	Ectopic preg	nancy	23	Month	delivery Day	Year
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Division Hospital or Attend 24 hours after death. Funeral Director:	ertifica	3 Suicide 6 Cou	estigation 28e. Place	ce of Injury - At hor	me, farm, street	, factory, office bu	ilding, etc.	28f. Location or Town		and Number	r or Rural	Route Number, City
Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	Medical Certification:	29a. Certifier 1 Certifying F	Physician: To the beaminer: On the basis and manners	of examination an								ause(s)
F 3 F 8	Me	29b. Signature and title of certification				29c, License O.C.M				Date signe cember 3		
	ł	30. Name and address of person				mara Street 5	Paltimara *	AD 24222				
St	ate	Ana Rubio MD. As	sistant Medical	Examiner 90 egistrar's Signatur		noie Street, E	оанипоге, М	ND 21223				

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 0615 am Valarie Mary 20 2010 Decembe /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Dorchester General Hospital Cambridge Dorche Ster If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours Months 1 M 2 F Days 218 34-8349 Director 128/1938 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm I'm I'm I'm an incominer must be notified at 1 ☐ Yes 2 ☐ No Funeral Director MD Dorchest HUrlock 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5905 21643 U.S.A Jeans 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or iten 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify Be Completed by Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ine Cold Water Sea 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Major 2 Indrew nthone ornish 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) whald P.O.BOX Hurlock 2164 permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ambrides 21 Signature of Funeral Service Licensee Hurlouk many land 21643 Smith Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** to enzelin 30 mi disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 10 xus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day 4 Pregnant at time of death signed by the at the detached for 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 \square Yes 2 \square No 3 \square Probably 4 \times Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 🗆 No 2 1 ☐ Yes Physician: the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be 1 ☐ Yes 2 🔀 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ EB/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D Hospital 1 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D26388 12-22-10 who completed cause of death (Item 23a) (Type, Print) 30 Name and address of person 302 CEllins Michael 32. Registrar's Signature 31. Date filed (Month, Day, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 1 1 1 4 2 5 4 State of Maryland / Department of Health and Mental Hygiene

		I- For State Registrar	C	Certificat	e of De	eath		F	Reg. No.		
Physiciai ledical Examin	n/ er	1. Decedent's Name (First, Middle,Last Lillie (apers						Day Year er 25, 2010		3. Time of Death 0230 hrs
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Funeral Director			X 7. Age (In yr	rs. last birthda 84		Under 1 Year onths Days			6, 1926	Foreign	hplace(State or ⁿ South ^{Intry)} Carolina
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th the Maryland 23a nr 28a-f sho	2 2	10e. Street and Number 227- 62nd Street				Zip Code 20019			10g. Citizen of Wh	Stat	es
	by Funeral		12. Was Decedent Ever in Armed Forces? 1 Yes 2 No No No Dates:	lo	If Yes, s	pecify Cuban	, Mexican, Puerl		White Specify:	, etc. 1ack	
1036 vithin 72 hours ene. sr than "natus Medical Ex m	mpleted	15. Decedent's Education (Specify or Elementary/Secondary (0-12) . 9th	Oollege (1-4 or 5+)	dur		working life.	ion (Give kind of DO NOT use re		16b. Kind of Bus		ndustry
ID 21215-0036 should be filed within 7 and Mental Hygiene. T'l is marked other than natic event, the Medica	8	17. Father's Name (First, Middle, Last) Lionel Sampson					Carrie	Fortune	Maiden Surname)		
MD 2 and 2 should allth and M may 1 is marraumatic	2	19a. Informant's Name/Relationship (T Katrina Ajibare/ 20a. Method of Disposition	Granddaught		16 Gr	amby S	St. Hyat	Rural Route Nu	mber, City or Towr Md . 20 20c. Location -	0789)
Baltimore, MC permit. Pages 1 and 2 s Department of Health at Important: If item 27		1 X Burial 2 Cremation 3 4 Donation 5 Other Specify: 21. Signature of Funeral Service Liven:	Removal from State	crematory Lincol	or other pl n Men	^{ace)} orial	1/4	/2011	Suitla	nd,	Md.
Physician	+	23a. Part I. Enter the disease, or comp failure. List only one cause on ea	ications that caused the de						estville rest, shock, or hea		20747 Approximate Interval Between Onset and
IN edical. Examiner		Immediate Cause (Final disease a.	Sharp Force Injuries Due to (or as a consequence							2	Death
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		events resulting in death) Last d. UNPENDED	Due to (or as a consequence	ce or);							
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 V No 9 Unknown	23c. If yes, outcome of p 1 Live birth Pregnant at time o	2	Fetal de		Ectopic pregr	nancy	23d. Date of o		ay Year
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Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed							1 ✓ Yes	psy pr prmed? de		opsy findings available ompletion of cause of S
irector	å	25. Was case referred to medical examiner?	lospital: 1 Inpatient 2	✓ ER/Outp	atient 3		of Death (Check	ing Home 5	Residence 6	Other:	
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Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Certification:	2 Accident Investigation 3 Suicide 6 Could not Industry 4 Homicide	28e. Place of Injury - A		, street, fac	ctory, office b	uilding, etc.	or Town,			al Route Number, City
To the Host within 24 ho To the Fun completely f	Medical	Check drift	an: To the best of my knowOn the basis of examinationand manner stated.	_							
	Ž	29b. Signature and title of certifier				29c. Licens		51	29d. Date signed		
22	_		nt Medical Examiner	111 Pe	nn Stree	et, Baltimo	ore, MD 2120	01			
Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registar's Sig	rature /							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) state Registra MEND#20bperFH, 12/28/10, BMW, MbCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PHILIP ΚY DANG DEC 2010 Medical 9:18 A 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S 14911 BELLE AMI DR. LAUREL Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) VIETNAM **Funeral** Date or Billion (Month, Day,) 1 X M 2 □ F Months Days Hours Min Director 216-33-1079 77 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD MONTGOMERY SILVER SPRING 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 3500 PEAR TREE CT. 20906 U.S.A. hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🏋 No If Yes, Give þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 ₩ Widowed 4 Divorced Year or Dates ASIAN 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4 ENGINEER ENGINEERING Be other traumatic event, 17. Father's Name (First, Middle, Last) 2 should be file h and Mental H 7 is marked ot 18. Mother's Name (First, Middle, Maiden Surname, UNK. UNK. မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau NGHIA DANG/SON 14911 BELLE AMI DR., LAUREL, MD. 20707 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 12-30 -2010 4 ☐ Donation 5 ☐ Other (Specify) CREMATORY 2010 RIVERDALE. 21. Signature of Funeral Service Licerises 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A M00091i 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) MYOCARDIAL INFARCTION Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and -transit executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death signed by the a Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, HYPERTENSION cate has been signage 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? HYPERCHOLESTEROL 24a Was an autopsy performed? 2 No Yes 2 V No 1 Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: SONS HOME မ 1 Tes 2 💢 No within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral director after this completed filled in by the funeral director. 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify, this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) MD D54486 DEC. 27, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20912

DHMH 17 Rev 7/2009

State

Registrar

TON THAT CHIEU, M.D.

28 2010

31. Date filed (Month, Day, Year)

Registrar's Signat

7505 NEW HAMPSHIRE AVE., SUITE 310, TAKOMA PARK, MD

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

State

31. Date filed (Month, Day, Year)

DEC

27

Registrar's Signature

10-09853 Doodley L. Derose Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of De Registrar Certificate of De			g. No.					
Physicia		Decedent's Name (First, Middle,Last)		2. Date of Death	i	3. Time of Death				
ledical Exami	ner	Doodley Linsey Derose 4a. Facility Name (if not institution, give street and number) 4b. C	ity, Town, or Location of Death	Month December	21, 2010 4c. County of Death	1443 hrs				
		,	lver Spring		Montgomery					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If	Under 1 Year If Under 24Hrs	8. Date of Birt	h (MM/DD/YYYY) 9. Birt					
Director		213-33-0483	onths Days Hours Min	May 22	, 1991 Foreign Cou	intry) Maryland				
япу		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits				
Aaryland 28a-f show Lat once.	ō	Maryland Montgomery	Silver Spri	ng		1 Yes 2 X No				
Maryl. 28a-1	Director		Zip Code	10	g. Citizen of What Coun	try?				
th the 23a or		1616 Hutchinson Lane	20906		ш.:	S.A				
ath wi	Funeral	1 X Never Married 2 Married Armed Forces? If Yes, s	cedent of Hispanic Origin? (Sp pecify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,				
ter de		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes	2 X No specify:		Specify:	Black				
ours at atural	d by		sual Occupation (Give kind of v		16b. Kind of Business/Ir					
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		rea)						
ID 21215-0036 should be filed within 72 and Mental Hygiene. 77 is marked other than 1 natic event, the Medical	ОШ	17. Father's Name (First, Middle, Last)	Student 18.Mother's Name	(First Middle M	ition					
215- e filed tal Hyl	Be C	Linois J. Derose	To. Would S Walle		ie Gelin					
21; ould b d Men s mar	70	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add	ress (Street and Number or F	Rural Route Numl	ber, City or Town, State,					
e, MD I and 2 sho Health and item 27 is r traumati		Linois J. Derose - Father 1616 Huz	tchinson Lane. (Name of cemetery,	Silver	Spring, MD	20906				
Ψ <u>=</u> =		1 W Buriat 2 Cremation 3 Removal from State crematory or other pl	ace)							
Baltimor cernit. Pages Department of Important: If		4 Donation 5 Other Specify: Gate of Heat 21 Signature of Funeral Service Licensee 22. Name	oen Cem. 12/	29/2010	Silver Spi	ing, MD				
Balti permit. Departm Imports injury o		21. Signature of Furieral Service Closenses 122. Name 11800	New Hampshir	nes-rina e Ave.,	Silver Spr	ing. MD20904				
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the more failure. List only one cause on the control of the cause of the cau				Approximate Interval Between Onset and				
Medical Examiner		Immediate Cause (Final disease a Gunshot Wound of Torso				Death				
		or condition resulting in death) Due to (or as a consequence of):								
	Пē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause								
Ь	Examiner	Cuisados or figury that initiated events resulting in death) Last upon to (or as a consequence of):								
and transi		d								
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876 ifficate		IF FEMALE: 23b. Was decedent pregnant in the appet 1.2 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de	eath 3 Ectopic pregna	ancy	23d. Date of delivery Month D	ay Year				
Box 687(death certifica he attending pl	Physician/	past 12 months / 4 Pregnant at time of death 5 Other (Į.	ļ				
O. Be tr the der by the	Phy	Part II. Other significant conditions contributing to death but not resulting in the under	ving cause given in Part I	23e. Did tob	pacco use contribute to t	ne cause of death?				
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rds, require been si	Completed			24a. Was a		opsy findings available				
BCO ne law te has ge 2 si	E E			autops perform 1 ✓ Yes 2	ned? death?	ompletion of cause of				
tal Recian: The certificate ector, page	Be C	25. Was case referred to medical	26.Place of Death (Check			_ [_]				
Vita bysici	2	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3			Residence 6 🗸 Other:	Scene				
Division of Vital Records, tal or Attending Physician: The law requir is after death. al Director: After this certificate has been is led in by the funeral director, page 2 should have the funeral director.	Ë	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury Dec 21, 2010 1330 hrs	28c. Injury at Work? 1 Yes 2 ✔ No	28d. Describe he Subject shot	ow injury occurred					
Atten Atten rector: by the	cati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, fac		28f. Location (St	treet and Number or Rur	al Route Number, City				
The state of the s										
So the first of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Suicide So Town, State) 1616 Hutchinson Lane, Silver Sp 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as s 17										
	Med	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	th, Day, Year)				
6		D_M	O.C.M.E.		December 22, 20	10				
		30. Name and address of person who completed cause of death (Item 23a)	C D III							
		Donna M. Vincenti, MD Assistant Medical Examiner 111 Per 31. Date filed (Month, Day, Year) 32 Registrar's Signature	nn Street, Baltimore, M	D 21201						
St Regist		OEC 27 2010								

		For	State of	Maryland	/ Depa	artment	of H	ealth a	and N	lental H	/gien	9) 1	n	1254
		State Registrar			Cer	tificate	of D	eath			Reg. N	lo.		7 L O 7
Physicia		1. Decedent's Name (First, Middle, Georgia Deni								2. Date of D Month Dece	eath mber	25,	(ear 2010	3. Time of Death 6:00 p
Medic Examin		4a. Facility Name (if not institution,	give street and numb	er)		4b. City, T	own, or	Location of	f Death		- 1	c. County of		
		Montgomery Ho	spice-Case	y House			Roc	kvil	le			Mon	tgome	ery
Funeral		5. Social Security Number	6. Sex 7 1 ☐ M 2 🔀 F	. Age (In yrs. last		If Under	1 Year Days	If Under 2 Hours		8. Date of B	irth		9. Birthpla	ace (State or Forei
Director		577-44-9470	TEM ZET	8	7 Yrs.					Sept.	13,	1923	O Guinti	Canada
nd how at	=	Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Town or Loc	cation							100	d. Inside City Limi
laryla 3a-f s iffied	ect	MD Mo	ntgomery	Roc	kvill	.e								1 🗌 Yes 2 🏋
or 28	₫	10e. Street and Number				10f. Zip (Code				10g. C	Citizen of Wh	at Countr	y?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	14639 Bauer D	rive, Apt.	103			208	353				US	A	
item;		11. Marital Status	12. Was Deced	ent Ever in U.S.		Vas Decede Yes, specif				cify Yes or No	-	14. Race -		
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nd 2 lealth m 27 her tr		Kathryn V. Arc	huleta/Dau	ighter	129	28 Ye	110	Jac	cet	Road,	Hage	rstow	n, MI	D 21740
Je 1a t of H If ite or ot		20a. Method of Disposition 1 Burial 2 Cremation	3 🗀 Removal from S	tate cem	netery, crem	sition (Name natory or oth	ner place			oate 27 ,	1	Location - C	•	•
t. Pag tmen rtant		4 Donation 5 Other (S	pecify)	Metr	opoli	tan C	rema	tory		10	AI	.exand	ria,	V A
permi Depar Impo any ir		21. Signature of Funeral Service Li	censee Lot	Mois	22 V 2 - F	. Name and 'ranci	Address J.	of Facility	Lins	Funer	al.H	Iome_I	nç.	, MD 209
		23a. Part 1 Enter the disease, or	complications that ca									er Sp		Approximate
Noveicies /		book, or heart failure. List or Immediate Cause (Final	nly one cause on eacl	line.	30 1701 01710		0, 0,9	, 50011 000						nterval Between Onset and Death
Physician/ Medical		disease or condition resulting in death)		an Canc									_	
Examiner				as a consequen	100 01).									
	лег	Sequentially list conditions, if any, leading to immediate	b. — Due to (or	as a consequen	ice of):								\top	
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exectan ar		resulting in death) Last	as a consequen	ice of):										
icate be executed physician and sthe burial-transit	edical	'	d										+	
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the decreased of the de	Physician/M	1 ☐ Yes 2 🙀 No 9 ☐ Unknown	9 Unkno			other tape	Ciiy)							,
requires that the death certific been signed by the attending p should be detached for use as	by Pi	Part II. Other significant condition	ns contributing to dea	th but not resulti	ing in the u	nderlying ca	use give	en in Part I.		23e. Did	tobacco	use contrib	ute to the	cause of death?
uires n sigr ald be	g p	Multiple Myel	oma							1 🗆	Yes 2	2 ¥ □ No 3	☐ Proba	bly 4 🗆 Unknow
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sician: The law s certificate has b irector, page 2 s	Be C	25. Was case referred to medical examiner?					26. Pla	ce of Death	n (Check		2 40 1			
hysic his ce Il dire	၉	1 Yes 2 X No	Hospital:	patient 2 - EP	l/Outpatien	t 3 🗆 DOA	Other	4 □ Nur	sing Ho	me 5 🗆 Res	idence	HO 6 🗷 Other	spice (Specify)	
ing P	ate:	27. Manner of Death 1 ↑ Natural 5 □ Pending	28a. Date of (Month)	injury 28 Day, Year)	b. Time of injury	- 1	c. Injury work?		- 1	28d. Describe	how inju	ry occurred		
ttend death tor: A	Certificate:	2 Accident Investig	ation			M		/es 2 □ I	-		10			
lor Ai after Direc	Cer	4 Homicide determi		f Injury - At home , etc. <i>(Specify)</i>	e, farm, Stre	et, factory,	опісе			28f. Location City or To			or Rural R	oute Number,
To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying	Physician: To the bes	at of my knowled	ge, death o	ccured at the	ne time.	date and o	lace, an	d due to the c	ause(s) a	and manner:	as stated.	
ne Ho n 24 l ne Fur pleted	Medical	(Check 2 Dedical Ex	caminer: On the basis Nurse Practioner: To	of examination ar	nd/or invest	igation, in m	y opinior	, death occ	curred at	the time, date	and plac	e, and due to	the cause	
To th To th comp		29b. Signature and title of certifier	~ ~				License	number				ate signed (/		
5		1 Notah	mille	R. CK	ENP		R14	3201			12	2/26	110	

DHMH 17 Rev 7/2009

State

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

1355 Piccard Drive, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Debrah Miller, CRNP

DEC 27 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ <u>4:</u>50 2010 Katherine Davenport December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Wicomico Nursing Home Salisbury If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 🗆 M 2 🗓 F Hours Months Days Director 97 -30-1913 214-07-7252 Maryland Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and items. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 611 Tressler Drive 21801 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15, Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Shirt Factory 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ W. Blades Annie George Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Salisbury, Maryland 21804 Wayne Davenport - Son 604 Sherwood Circle, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Cem. 12-30-2010 Mardela Springs. Mardela Signature of Juner Service Licens 22. Name and Address of Facility Bounds Funeral Home Salisbury, Maryland 23a. Part 1. Enter the disease, or correlations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) executed signed by the attending physician and deed be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performen: this certificate has death? 2 X No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at funeral Certificate: 28d. Describe how injury occurred Director; After 1 Natural injury 5 Pendina 1 🗌 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year)

State Registrar DHMH 17 Rev 7/2009 32. Registrar's Signature

RELAND

910 Eastern Shore Drive Salisbury Md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mahesha Thimarayappa M.D.

29

31. Date filed (Month, Day, Year)

8

21804

10-09830 Miranda Edwards

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 0 amend State of Maryland Poepartment of Health and Mental Hygiene

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		1- For State Registrar	Certificate	e of Death		Reg. No.				
Physic Medical Exam		Decedent's Name (First, Middle,Last)	_		2. Date of D	Death Day Year Der 20, 2010	3. Time of Death 1526 hrs			
redical Exam	mici	Miranda Edwa 4a. Facility Name (if not institution, give street and nur		4b. City, Town, or L		4c. County of Death				
		Prince Georges Hospital Center		Cheverly		Prince George	e's			
Funera Directo			7. Age (In yrs. last birthda	y) If Under 1 Year Months Days	Hours Min.	Birth (MM/DD/YYYY) 9. Birt 1960 Foreig	n			
		159-68-5409 1 M 2 F Usual Residence of Decedent	55	Yrs.	Aug.	28, 1955 Per	insylvania			
any.		10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits			
Maryland 28a-f show d at once.	Ē	Maryland Montgomery			Rockville		1 X Yes 2 No			
e Mary or 28a-	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cour				
hours after death with the Maryland "natural", or items 23a or 28a-f sho Examiner must be poptifed at once	E	200 Frederick Road 11. Marital Status 12. Was Deck	edent Ever in U.S. 13	20850 . Was Decedent of Hispo	anic Origin? (Specify Yes or	United Sta	tes can Indian, Black,			
death or item	Funeral	1 Never Married 2 Married Armed Fo			Mexican, Puerto Rican, etc.)	White, etc.				
		3 Widowed 4 X Divorced If Yes, Give Year or Dates:		Yes 2X No		Specify: Afri				
2 -	ompleted	15. Decedent's Education (Specify only highest grad Elementary/Secondary (0-12) College (1-	durir	ng most of working life.	n (Give kind of work done OO NOT use retired)	16b. Kind of Business/li	ndustry			
036 rithin 7 sne. r than	햩	4		Administr	ation	VA Hospi	tal			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	ပ္သ	17. Father's Name (First, Middle, Last)		18	3.Mother's Name (First, Middle	e, Maiden Surname)				
2121 hould be fill is marked its cvent,	o Be	James Wade 19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address (Street a	Marlene and Number or Rural Route N	lumber, City or Town, State	unk.			
		Michael N. Edwards, II -	Son 2210) Via Blanc	a Unit A Oce					
ore, sslam of Heal If item		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal fro		sposition (Name of ceme or other place)	• •	20c. Location - City or	Town, State			
Baltimore, permit. Pages I an Department of Hee Important: Lite		4 Donation 5 Other Specify:	Lee'	s Crematory	1/6/2011		, Maryland			
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum.		21. Signature of Funeral Service Liberisee			of Facility Stewart g Road NE Wa		, Inc. 20019			
Physician		23a, Part I. Enter the disease, or complications that ca failure. List only one cause on each line.					Approximate Interval Between Onset and			
/Medical examiner		Immediate Cause (Final disease a. Pulmonary	Thromboemboli				Death			
		b	consequence of):							
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a cause. Enter Underlying Cause	consequence of):							
	Examiner	(Lisease or injury that initiated	consequence of):							
ecuted and - transi		d								
icate be executed ficate be executed physician and the burial - transit	Medical	UNPENDED AMENDED				Leave the				
68760, certificate bo nding physic se as the bur	_	22h Mos desedont present in the	2 Fetal death 3 Letopic pregnancy World Day Year							
Box 68's death certificate attending	hysician	1 Yes 2 No 9 V Unknown 9 Unknown	nt at time of death 5	Other (Specify)						
the d	된	Part II. Other significant conditions contributing to		the underlying cause giv	en in Part I. 23e. Did	d tobacco use contribute to t	he cause of death?			
ires that the signed by	d by	-			1 🔲 ነ	res 2 No 3 Prob	ably 4 🗹 Unknown			
ords w requir	ompleted					topsy prior to co	opsy findings available ompletion of cause of			
Reco The law cate has	Com			_		rformed? death? s 2 No 1 ✔ Yes	s 2 No			
n of Vital Records, diag Physician: The law requir After this certificate has been s funeral director, page 2 should l	Be	25. Was case referred to medical examiner?	patient 2 🗸 ER/Outpat		f Death (Check only one) ther Nursing Home 5	Basidana 6 Ohan				
of Viting Physics After this tuneral directions	6	27. Manner of Death 28a. Date of	f Injury 28b. Time			Residence 6 Other:				
ision (Atteodia er death rector: At	ation	1 Natural 5 Pending 2 Accident Investigation	Day,Year)	1 Ye	s 2 No					
Division tal or Atteodir rs after death al Director: A	ertification:	3 Suicide 6 Could not be 28e. Place	of Injury - At home, farm,	street, factory, office buil	lding, etc. 28f. Location or Town	(Street and Number or Run , State)	ral Route Number, City			
Divi ospital or hours afte uneral Dir	U	4 Homicide determined (Specify) 29a. Certifier A Continue Physician To the best	of much mounts do a do able o		and along and due to the or					
To the Hospital within 24 hours: To the Funeral completely filled	edical	(Check only 1 Certifying Physician: To the best only 2 Madical Examinar: On the basis of and manner sta	examination and/or invest							
F 3 E 8	Me	29b. Signature and title of certifier	ted.	29c. License r	number	29d. Date signed (Mon	th, Day, Year)			
		leure Hall	dv_	O.C.M.	.E.	December 21, 20	10			
2		30. Name and address of person who completed cause Carol Allan, MD Assistant Medical E		nn Street, Baltimor	e. MD 21201					
	tate	31. Date filed (Month, Day, Year) 32. Reg	istrate Signature	·	-, 2.201					
Regis			D MARAKAN							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6:05 Å. M Physician/ FELDMAN December 26,2010 Clare S. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring 4c. County of Death Montgomery **Examiner** Holy Cross Hospital 5. Social Security Number 7. Age (In yrs. last birthday) 82 yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 0ct. 29 9. Birthplace (State or Foreign **Funeral** 409-42-0820 1 □ M 2 💢 F Days Hours .928 Memphis **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c City, Town or Location Silver Spring 10d. Inside City Limits Director Montgomery 1 Ves 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 20904 U.S.A. 3116 Gracefield Rd. #118 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married ģ 12 should be filed within 12.11-----alth and Mental Hygiene.
n 27 is marked other than "natural", o 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Regina Felsenthal မ Solomon Milton J. 19a. Informant's Name/Relationship /Type, Print)
James Feldman / spouse 3116"""GAGE&FTETG" NGC;;"#116"; "STT VEF TSPATHG;, CMarylagd permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau once, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Dec. 28,2010 Olney, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Day's Death Immediate Cause (Final Physician/ Hemorrhagic Stroke disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Years Hypertension Sequentially list conditions if any leading to improve cause. Enter Underlying ا-ransit الم Years requires that the death certificate be executed Atrial Fibrillation Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day 1 Yes 2 9 Unknown signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End Stage Alzheimer's Dementia, Chronic KIdney 23e. Did tobacco use contribute to the cause of death? Ş. Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Alo 24a. Was an Disease has autopsy performed' Yes 2 of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 ANO Other: မ 1 Hnpatient 2 ER/Outpatient 3 E 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) thours after death.

uneral Director; After the funeral Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Matural 5 Pending Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29d. Date signed (Month. Day, Year) Burbara Bupanich RSM MD D 0065 485 12/26/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd., Silver Spring, MD 20901 Barbara Supanich, RSM, MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

DEC

28 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 22 8:10a M Physician/ 2010 Samuel E. Frishman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda 6708 Pawtucket Road 9. Birthplace (State or Foreign Country) Pennsylvania If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 🗆 F Months Days Hours Min. 82 Director 189-20-1782 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Bethesda Maryland Montgomery 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral u.s.A. 20817 6708 Pawtucket Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

X Yes 2 No 1946þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural", 1949 Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic
once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pharmacy Pharmacist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Rose Ungerovitch Jacob Frishman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) #405, Washington, DC 20009 NW. 2853 Ontario Road, Bruce Frishman - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place) 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State ing David Mem.Grdns. 12/24/2010 | Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licensee Olal 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disea Immediate Immediate Cause (Final Physician/ Sudden Cardiac Death disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Years Diabetes Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) s been signed by the attending physician and should be detached for use as the homes. Years Hospital or Attending Physician: The law requires that the death certificate be executed Huperlipidema that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Years Hupertension Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy page 2 performed? 1 ☐ Yes 2 🗶 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 💢 No 1 Yes 4 Nursing Home 5 X Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2 29b. Signature and title of certifie

Registrar

State

8

nen U.

Brent Berger,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

D37840

10215 Fernwood Road, Suite 100A, Bethesda, Maryland 20817

December 22, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene,
Amend Items 10c,e,f per inf., g911,01/21/2011dhb

Reg. No. 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 December 4:15 A Eric Wilfrid Fleisher Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery **Rockville** Casey House 8. Date of Birth (Month, Day, Year) Country)
Tanuary 31,1926 Washington,DC If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 **X** M 2 □ F Months Days Hours Min Yrs Director 84 577-52**-**8971 Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location be notified at Director 1 Yes 2 X No Bethesda Potomac Maryland | Montgomery 10e. Street and Number 8300 Thoreau Drive 10f. Zip Code 10g. Citizen of What Country? Funeral -2085420817 United States 23a 7958 Inverness Ridge Road Examiner must items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. Black, White, etc. ò þ 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give 19 Baltimore, Maryland 21215-0036 If Yes, Give 1943–1948 Year or Dates. 1 ☐ Yes 2 🙀 No Specify. Specify: Caucasian "natural" Completed 3 X Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. other than " life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government 12 5+ Foreign Service Officer permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other Emphijury or other traumatic event. the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Greta Sundberg B. Wilfrid Fleisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arne Fleisher, son 7958 Inverness Ridge Road, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State Donation 5 Other (Specify Lincoln Crematory 12/23/2010 Brentwood, Maryland Fort Simple Tribute Funeral & Cremation 22. Name and Address of Facility 21. Signature of Fundar Service Li-M0020 Center are 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician. Metastatic Prostate Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, executed burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physician Physician/Medical Physician: The law requires that the death certificate be P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year detached for 5 Other (specify) Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det þ Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 Yes 2 No Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No 4 Nursing Home 5 Residence 6 Other (Specify Casey House 1 Inpatient 2 ER/Outpatient 3 DOA မ completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred s after death. I Director: After t Certificate: To the Hospital or Attending 1 🗶 Natural 5 Pending M 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

>

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2010

Dr. Bindu Joseph,

31. Date filed (Month, Day, Year)

DEC

D0060632

6001 Muncaster Mill Road, Derwood, Maryland 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Fippin James December 19,2010 Physician/ Howard 9:10A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 8117 Quentin Street New Carrollton g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Dec. 2, 1940 Days Hours Min. Virginia 1 🕅 M 2 □ F 555-58-3420 70 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Prince George's New Carrollton Maryland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States Quentin Street 20784 8117 12. Was Decedent Ever in U.S.
Armed Forces?
1 2 Yes 2 1 No
1f Yes, Give 1961–1963 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. ğ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Riggs National Bank Banker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Colin Trigg Junkin William Howard Fippin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 8117 Quentin Street New Carrollton, MD 20784 Jean P. Fippin -wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland National Mam. Park 12/22/2010 1 🔼 Burial 2 🗆 Cremation 3 🗆 Removal from State Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen එonald Av∵sBorgwardt Funeral Home, PA 2000 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or compile alons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Arrythmia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sleep Apnea Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): ie attending physician and ed for use as the burial-transit Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension Due to (or as a consequence of) resulting in death) Last Physician/Medical Coronary Artery Disease Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 2 No 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Obesity; COPD Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No has 1 Yes 2 No certificate sompleted filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA မ within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10+1 December 20, 2010 52119 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Sridhar Chatrathi, M.D. 7500 Hanover Parkway,#104 Greenbelt, Maryland 20770

State

Registrar

31. Date filed (Month, Day, Year)

UEC

27

2010

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2010 Phv11is Dowling 24, Dec. 6:09 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Tranquility at Fredericktowne Frederick 8. Date of Birth (Month, Day, Year) May 26, 1931 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😿 F Months Days Hours Country) **Ireland** Director 79 577-56-5058 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. Count 10d. Inside City Limits Director Frederick Walkersville 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21793 8317 Revelation Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 2 1 Never Married 2 Married 1 Yes 2 No Specify: White If Yes, Give Specify. 3 ₩idowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ John Dowling Mary Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Bovill/Daughter 103 Lombardy Drive, Middletown, MD 21769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Dec. 29. Gate of Heaven Cemetery 4 Donation 5 Other (Specify) 2010 Silver Spring, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1, Enter the disease, o co shock, or heart failure. List on olications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) ova suelav Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last use as the burialattending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Por Month Day Year Pregnant at time of death signed by the a d be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 autopsy performe certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Livin examiner? Assisted Other: 4 Nursing Home 5 Residence 2 🗭 No 1 Inpatient 2 ER/Outpatient 3 DOA ျ 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h. Time of 28c. Injury at After Natural Accident 5 Pending work? nours after death.

neral Director: Aft
filled in by the fur Investigation 2 No Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npleted within 2. To the 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

28 2010

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Muhammad K. Waseem, MD 1126 Opal Court, Hagerstown, MD 21740

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #state of Maryland / Department of Health and Mental Hygiene State
State
Registra, AMEND#25 perMD, 12/29/10, BWW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gitlin Ellipt Medical December 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11213 Buckwood Lane Rockville Montgomery 5. Social Security Number . Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🕱 M 2 □ F Days Months Hours Min. 08/16/1928 New York Director 126-20-0737 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery 1 X Yes 2 No Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11213 Buckwood Lane 20852-3607 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces' 1952-1959 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 250 Black, White, etc. 1 Never Married 2 Married Completed by Beltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 Divorced Specify: Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Architect Architecture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Benjamin Gitlin Jessie Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther Gitlin, wife 11213 Buckwood Lane, Rockville, Maryland 20852-3607 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem Gdns 12/19/2010 Falls Church, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 Rockville Pike, Rockville, Maryland MO1255 20852 23a. Pa. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury AlZheiners that initiated events Due to (or as a consequence of): resulting in death) Last burial-Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sate has been signe page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed' Yes 2 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation within 24 hours after deal To the Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) pleted filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 37142 12-17-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville MD G. Coleman Piccard Dr MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

28 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Donald Marvin Gardner Dec. 22, 2:10 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Arcola Health & Rehab. Center Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) Sept. 13, 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Country) D.C. 1 X M 2 - F Days Hours Director 579-10-2002 90 1920 Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code 10a, Citizen of What Country? Funeral 11714 Lytle Street 20902 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ▼ Yes 2 □ No Black, White, etc. 2 1 Never Married 2 KM Arried Baltimore, Maryland 21215-0036 effort. Page 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or White 1 Yes 2 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 1 042 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Military Sealift Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Specialist Command Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, ပ George Dewey Gardner Dora Elizabeth Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Lillian G. Gardner/Wife 11714 Lytle Street, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20 cemetery, crematory or other place) Dec. 2010 1 Burial XX Cremation 3 Removal from State Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Alzheimer's Disease Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death g 🗌 Unknown detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed upleted filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform 2 1 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 X No ္ဝ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 28b. Time of Certificate: 28d. Describe how injury occurred After ! Natural
Accident
Suicide injury 5 Pending To the Hospital or Attendin ↑ within 24 hours after death. ► To the Funeral Director: After completed filled in by the fun 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practifier: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) D09834 Dec. 23, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Barry Rosenbaum, MD 3720 Farragut Avenue, Kensington, MD 20895 31. Date filed (Month, Day, Year) State Registrar's Signature

Registrar

Box 68760

P.O.

Records,

of Vital

Division

10-09756 Barbara Greene Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ 0120 hrs **Medical Examiner** December 18, 2010 Barbara Virginia Greene 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Salisbury Wicomico 1704 Dale Lane 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth/MM/DD/YYYY 9. Birthplace (State or **Funeral** Foreign Country) Min Months Days Hours Director 62 218-50-1150 1 M 2X F 30, 1947 Maryland Dec. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No 28a-f show Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Heath and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once, MD Wicomico Salisbury 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 苬 1704 Dale Lane 21801 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12 Was Decedent Ever in U.S. 14 Race - American Indian Black. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married Armed Forces? Yes 2X No Specify: Black 4 Divorced If Yes, Give Year 1 Yes 2X No specify: ğ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Laborer Centre At Salisbury 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Dashiells Herman Greene, Sr. 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly G. LeGrand/ Sister 590 Oakwood Circle - Petersburg, VA 23805 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12/27/2010 Salisbury, MD Green Acres Memorial Park 4 Donation 5 Other Specify Signature of Funeral Service Licens 22. Name and Address of Facility Salisbury, Maryland Dapel - 1213 Jersey Road 21801 Jolley Memorial Chapel ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** 23a. Part I. Enter the disease, or comp Between Onset and failure. List only one cause on ex /Medical Death a Gunshot Wound of Torso Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last attending physician and for use as the burial - transit certificate be executed sician/Medical UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Day past 12 months? Pregnant at time of death 5 this certificate has been signed by the attr director, page 2 should be detached for 1 Yes 2 No 9 V Unknown Unknown 뮨 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 Yes 2 ✔ No 3 Probably 4 Unknown pleted 24a, Was an 24b. Were autopsy findings available pnor to completion of cause of autopsy performed death? Com Yes 2 No 2 No this certificate 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 26.Place of Death (Check only one) 25. Was case referred to medical B Other₄ examiner? Nursing Home 5 Residence 6 Other: Scene Inpatient ER/Outpatient 3 2 1 🗸 Yes 28a. Date of Injury FOUND: Day Year 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: Subject was shot FOLIND Natural 1 Yes 2 ✓ No Pending filled in by the Dec 18, 2010 0115 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 1704 Dale Lane, Salisbury, MD determined (Specify) Residence 4 Momicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number December 18, 2010 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature backe State

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

ULU

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#12per INF, 1/3/11, BMW, McCo Certificate of Death 2, Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 8:30pm M 2010 December John Wesley Hepburn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville National Lutheran Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number **Funeral** oct. 15, Months Days Hours 1 M 2 - F Washington, DC T919 Director 91 579-<u>10-7463</u> Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 United States 9716 Watts Branch Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes 2 1942 If Yes, Give 1942 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 - Widowed 4 - Divorced -1967 Year or Dates 1951event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene, is marked other tha United States Army Colonel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. Mary White Arthur Wesley Hepburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9716 Watts Branch Drive, Rockville, MD 20850 Elizabeth L. Hepburn (Spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Ukn cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia Arlington Nat'l Cem. 22 Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 21. Signature of Funeral Service Licenses M00689 Part (Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Heart Immediate Cause (Final oncestive Unysician/ disease or condition Medical resulting in death) Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Sterosts 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) December 22,2010 20+1 DOD64624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sandeep Sharma, M.D., 743 Summer Walk Drive, Gaithersburg, MD 20878 31. Date filed (Month, Day, Year) 32, Registrar's Signature 28 2010 Registrar becan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 21, 6:00 p M 2010 Μ. Houchens Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Renaissance Gardens at Riderwood Village Silver Spring Prince George's If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex . Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Country Germany 1 ☐ M 2 ☐ X Months Jan. 8, Year 918 Director 579-46-9813 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Prince George's Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 USA 3160 Gracefield Road, RG-1523 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3905 Periwinkle Drive, Fort Worth, TX 76137 Erich Houchens/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Dec 23, 1 Durial 2 🔀 Cremation 3 D Removal from State Metropolitan Crematory Alexandria, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lig 22 Tame and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Arteriosclerotic Cardiovascular Disease Physician Medical resulting in death) Due to (or as a consequence of): Examiner Hyperlipidemia Sequentially list conditions, Examine July to lot as a nonsequence of if any leading to immedia cause. Enter Underlying Cause (Disease or iinjury the attending physician and shed for use as the burial-ten in Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? detached for Month Pregnant at time of death 9 Unknown 9 Unknown signed by tell be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus, Type II 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? Atrial Fibrillation 24a. Was an certificate has autopsy 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 🗵 Nursing Home 5 🗌 Residence 6 🗆 Other (Specify) 2**★** No မ 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital within 24 hours To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Ecertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3160 Gracefield Road, Silver Spring, MD 20904 Eileen Gemmell, CRNP 31. Date filed (Month, Day, Year, 32. Registrar's Signature State DEC 27 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day}2, 2010 December 1:38 a Bashta Hauck Helen Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Holy Cross Hospital 8. Date of Birth (Month, Day, Year) Aug. 4, 1926 Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X** F Days Min Hours CT Director 84 044-22-0629 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location the Maryland Director 1 ☐ Yes 2 🎦 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20901 USA 9626 Brunett Avenue within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 ☐ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ith and Mental Hygien 27 is marked other the traumatic event, the 12 Navy Dept. Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, pe Eva Telep Nicholas Bashta and 2 should be Health and Mer tem 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9626 Brunett Avenue, Silver Spring, MD 20901 Neil McRae Hauck/Son permit, Page 1 and 2 Department of Health Important: If item 27 any injury or other th Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 24 Dec 4 Donation 5 Other (Specify) 2010 Silver Spring, Md 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, Trekard I Hales MD 20901 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician, Acute Hypercarbic Hypoxic Respiratory Failure Medical resulting in death) Due to (or as a consequence of) **Examiner** Congestive Heart Failure Exacerbation Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and Hospital or Attending Physician: The law requires that the death certificate be executed Systemic Inflammatory Response Syndrome that initiated events resulting in death) Last Due to (or as a consequence of) buria attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Yea Day Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed pluods 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 1 🖈 Inpatient 2 □ ER/Outpatient 3 □ DOA ၉ After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of Certificate: 28c. Injury at Natural 5 Pending wor 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: A Investigation 6 Could not be Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) Dec. 22, 2010 D63579 10 of death (Item 23a) (Type, Print) 30. Name and address of person who completed of 500 Glen Road, Silver Spring, MD 20910 Martia Tayaq, Forest

State

Registrar

31. Date filed (Month, Day, Year,

27

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year ALICE V. HUGHES <u>December</u> Medical 201 5:05 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BERLIN NURSING & REHAB CENTER BERLIN WORCESTER 5. Social Security Number 6. Sex If Under 1 Year 9. Birthplace (State or Foreign Country) NEW YORK 7. Age (In yrs, last birthday) If Under 24 Hrs. 8. Date of Birth Funeral Months Days Min. (Month, Day, 1 🗆 M 2 🗓 F Hours Director 89 100-16-3323 Usual Residence of Decedent 28a-f show 10b. County 10a State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director NEW JERSEY 1 ☐ Yes 2 🙀 No BERGEN **PARAMUS** 6 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a120 WILLOW BROOK CT. 07652 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ò þ 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 XWidowed 4 ☐ Divorced WHITE "natural" Completed Specify: Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BOOKKEEPER REAL ESTATE Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Page 1 and 2 should be ment of Health and Ment JOHN NEWMAN ISABELLE MORGAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau PETER HUGHES/SON 861 OCEAN PARKWAY, OCEAN PINES, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) CREMATORY OF DELMARVA 12/23/10 DELMAR, DELAWARE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one company on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Lind Stage Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Dav Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 No Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 🖪 No Division of Vital Hospital or Attending Physician: To Be 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide work? injury 5 Pending 2 🗌 No s after death filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) To the Hospital within 24 hours or To the Funeral Completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only on 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu e and title of certifier 29d. Date signed (Month, Day, Year) K13513 completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month) Registrar's Signature State DEC 29 Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joe Thomas Hearn 10:45 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** alisbur VICOMIC Ponins la Regional Madicul cento If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days July 29 Year 1931 1 X M 2 □ F Months Hours Delaware 79 222-18-4987 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at rector Parsonsburg 1 Tes 2 X No Maryland Wicomico ā 10e. Street and Number 10f. Zip Code ö 10g, Citizen of What Country? Examiner must be items 23a Funeral USA 21849 32013 Old Ocean City Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ់ δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify. White Completed 3 X Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Building Inspector Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Hearn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32013 Old Ocean City Road, Parsonsburg, MD 21849 Ronnie Hearn/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or 1 Burial 2 XCremation 3 Removal from State 12/27/2010 Delmar, Delaware Delmarva 4 Donation 5 Other (Specify Crematory 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury 21. Signature of Funeral Service Liq any a, P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death ock, or heart failure. List only one care e on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Precimonia Medical Due to (or as a consequence of) Examiner COPD Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical as the IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day Year _ Yes detached the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 🗌 Yes 2 No Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: or Attending Natural 5 Pending 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the d 29a. Certifier (Check To the within 2 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier me and address of person who completed cause of death (Item 23a) (Type, Print) TATHONY mD 100 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2155 M Medical Hall 10 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death lisba Padiamal Wiromico ninsuld Social Security Number If Unde If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months 1 🗆 M 2 💢 F Davs Hours Min. (Month, Day, Year) 4-24-1929 Country)
Maryland Director 217-24-6718 81 Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral 8632 N. West Road 21801 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifford Chinault Eleanor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth A. Hall - Husband West Road, Salisbury, Maryland 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Creamtory of Delmarya 12-31-2010 Delmar, Delaware Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine Due to (or as a consequence of) physician and s the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 5 Other (specify) Month Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician; The law page 2 2 4 1 ☐ Yes 2 ☐ No 25. Was case referred to medical completed filled in by the funeral director, Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and addre of person who completed cause of death (Item 23a) (Type, Print) Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2021 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SHADY GROVE ROCKVIL MONTGOMERY If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) Date of Biru. (Month, Day, Yea Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 □ M 2 🔀 F 73 SUDAN Director 28a-f show 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director DARANSTOWN MONTGOMERY 1 Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a ANCIENT 20878 SUDAN 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify "natural", BLACK 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) MAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F is marked o ELSAIG HUSSEIN 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SKYRON PL. AMAL SULIMAN ZON 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) injury or 12/31/10 OMDURMAN SUDAN 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ADEN MUSLIM FUNERAL SER 21. Signature of Funeral Service Licensee Wille Bell & ST. WOODBRIDGE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myccardial disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): and I-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): I physician a s the burial-1 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Dav Year 1 Yes 2 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier D64068 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KALARIA M.D. 9901 MEDICAL CENTER DR. ROCKVILLE MD Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Records,

of Vital

Division

State of Maryland / Department of Health and Mental Hygiene 1 - State Amend #20b date, per FHDR, HCHDertificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ Helfrich 102 ICINCL 20 Dec Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2**X** F Months Hours Min. Aug 29, I921 Country) England 261-36-2573 89 Director Usual Residence of Decedent show 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland at 10a, State 10c. City. Town or Location Director items 23a or 28a-f s er must be notified 1 Yes 2 No MD Ellicott City Howard 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21042 5330 Dorsev Hall Rd. Apt 335 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or iter Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 🎞 No Specify If Yes, Give Year or Dates. White 3X Widowed 4 ☐ Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 if Health and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) the own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unknown Lillian Louise Gorby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary D. Lake 9542 Oakhurst Dr. Granddaughter Columbia, MD 21046 20b. Place of Disposition (Name of cemetery, crematory or other place Arlington National 20a. Method of Disposition 20c. Location - City or Town, State Page 1 ament of 8 permit. Page 1 Department of Important: If it Burial 2 Cremation 3 Removal from State 2/1/2011 ò Arlington, VA injury o 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facili Harry H. Witzke's Family FH, Inc. 21. Signature of Funeral Service License 4112 Old Columbia Pike Ellicott City, MD 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ cholangitir disease or condition Medical resulting in death) Due to (or as a consequence of): common bile duct stores and Examiner obstructing Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last law requires that the death certificate be executed and Due to (or as a consequence of): physician Physician/Medical Box 68760 the use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Year Day Pregnant at time of death g Unknown P.O. Part !!. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ acute senal tailure reproton Failure Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? DIL 24a, Was an performed' , when is transaminition 1 Yes 2 No 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending Natural 5 Pending hours after death.

neral Director: Aft

filled in by the fur 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сопріете (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00066515 Dec 20 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 5755 Cedar Lane Columbia, MD Nishi Rawat, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

18 at 28 Aut 3

10-10040 Sarah Marion Jackson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible	1.9	5	5	
State of Maryland / Department of Health and Mental Hygiene	-	0	1	-

	1- For State Registrar		Certifica	ate of	Death				Reg. No.		
Physician/ ledical Examine	Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year December 28, 2010							3. Time of Death 0320 hrs			
1	4a. Facility Name (if not institution Southern Maryland H			41	o. City, Town, Clinton	or Location of	of Death			ounty of Dea nce Georg	
Funeral Director	5. Social Security Number 577–02–5228		In yrs. last birth	nday) Yrs.	If Under 1 Y Months D	ear If Unde ays Hours	Min.		3irth (MM/DD	Fore	irthplace (State or ignWashington, ountry) D. C.
any	Usual Residence of Decedent 10a. State 10b. County		c. City, Town		n I			oune			10d. Inside City Limits
È .	Maryland Prin	ce Georges	For	estv	ille 10f. Zip Code				10a. Citizer	of What Co	1 XX Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.					2074	7			Uni	ted St	ates
or death w	1 3 Widowed 4 Div	12. Was Decedent Ev Armed Forces? 1 Yes 2 X vorced or Dates:		If Ye	Decedent of s, specify Cult	an, Mexican				White, etc.	rican Indian, Black, Black
5-0036 led within 72 hours after Hygiene. other than "natural" the Medical Examine Completed by		cify only highest grade comple			s Usual Dccu st of working I				16b. Kind	d of Business	/Industry
5-0036 lied within 72 hour Hygiene. d other than "natu the Medical Exauth the Medical Exa		2 years		egis	tered		's Nomo /	Firet Middle	Kai , Maiden Su		ermanente
De fi inted irked	Eugene Th	omas, Sr.				F1o	renc	e Ma	e Bur	riss	
e, MD 21 I and 2 should Health and Me item 27 is ma	Bobby Earl Ja	ckson (Husband	1) 28	04 L		st Ave	nue;	Fores	tville	Mary]	land 20747
ore, slan of Hea If ite	20a. Method of Disposition 1	pecify:	cremato	ory or othe nal I	Harmony	у Мето	Jan. rial		Lan	dover,	or Town, State Maryland
Baltimo permit. Page Department of Important: injury or oth	21 Sign sure of Funeral Services	Licensee									Morticians, gton,D.C.200
Physician /Medical	23a. Part I. Enter the disease, or failure. List only one cause	on each line.	e death. Do no		e mode of dyir	ng, such as c	ardiac or	respiratory a	errest, shock	, or heart	Approximate Interval Between Onset and Death
≛xaminer	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ		Idel							
ted Insit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or lightly that Liftated events resulting in death) Last	Due to (or as a consequ									
executed an and al - transit		d AMENDED 23a	pt.II,	27 p	er me	g913 3	-2-1	1 vt			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transignal Certification: To Be Completed by Physician/Medical Especial	IF FEMALE: 23b. Was decedent pregnant in t past 12 months? 1 Yes 2 No 9 Un	23c. If yes, outcome 1 Live birth 4 Pregnant at tirk known 9 Unknown	2		al death er (Specify)	3 Ectopio	pregnan	су		Date of delive	pry Day Year
, P.O. B res that the d signed by the be detached of by Phy	Hypertensio	tions contributing to death b	ontributing to death but not resulting in the underlying cause given in Part I.			rt I.	1			o the cause of death?	
of Vital Records, lag Physician: The law requires the tribicate has been signered director, page 2 should be not To Be Completed								рег	as an copsy formed?		
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ion of Vit tending Physic eath, tor: After this of the funeral dire	1 Yes 2 No	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day, Year	2 V ER/Ou	itpatient ime of Inj	jury 28c. li	njury at Work	? 2		Residence how injury	e 6 Oth	er:
Division os spital or Attending tours after death. neral Director: After filled in by the fune. Certification:	1 Natural 5 Pen 2 Accident Inve	ding estigation 28e. Place of Injur	y - At home, fa	rm, street		Yes 2		28f. Location	(Street and	Number or F	Rural Route Number, City
Divisi Hospital or At Puneral Direct tely filled in by	29a. Certifier	Ild not be (Specify) Physician: To the best of my k	nowledge, dea	th occurre	ed at the time	date and pla	ace, and o	or Town	use(s) and r	manner as sta	ated.
To the How within 24 by To the Funcompletely Medical	1 11	aminer: On the basis of examinand manner stated.	nation and/or in	nvestigatio	29c. Lice	nse number	curred at	the time, da	29d. Da	te signed (M	onth, Day, Year)
	30. Name and address of person	n who completed cause of dea	th (Item 23a)		0.0	C.M.E.			Decer	mber 29, 2	2010
23	Victor Weedn MD JD	Assistant Medical E	xaminer		Baltimore	Street, B	altimor	e, MD 21	223		
Stat Registra		32. Registras	Sign Ture								

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 8, Elizabeth Johnson 1339 hrs M Deborah 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince Georges 3938 - 23rd Parkway; Apt. 12 Temple Hills 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex Year) 11, 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F 579-70-8588 59 Washington, D. C. Director November Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location within 72 hours after death with the Maryland Director Temple Hills 1 X Yes 2 □ No Maryland Prince Georges 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20748 United States 3938 - 23rd Parkway; Apt. 12 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. à 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: 3 Divorced 4 Divorced **Black** Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) (Specify only highest grade completed) during most of working filed within 72 ial Hygiene. D. C. Department of Elementary/Seconday (0-12) College (1-4 or 5+) Finance & Revenue years Tax & Revenue Examiner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked of any injury or other traumatic even once. Emma Elaine Ross William Henry Johnson, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13106 Thackery Place; Germantown, Maryland 20874 Heath Douglas Johnson (Son) 20a. Method of Disposition
1 ☐ Burial 2 【★Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dec. 28°, 2010 Riverdale Park Crematory 4 ☐ Donation 5 ☐ Other (Specify) Riverdale, Maryland 21. Sinnature V Funeral Service 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington , D.C.20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Atherose Immediate Cause (Final erotic Cardiovascu Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and I for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4. Inknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No After this certification, properties 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred After 1 1 X Natural 5 Pending 1 🗌 Yes 2 🗀 No Accident within 24 hours after death

To the Funeral Director: A
completed filled in by the f Investigation Suicide 6 Could not be Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Cortifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) , 2010 December 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salvador Sylvester, M.D.; 255 Rockville Pike; Suite 125; Rockville, Maryland

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9:00 a M December 2010 Daniel Barr Kraft Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Rockville Montgomery Casey House If Under Social Security Number If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral 6. Sex Age (In yrs. last birthday) 1 ★ M 2 □ F Months Davs Hours **Director** 04/12/1949 Washington, 578-62-3053 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director 1 XYes 2 No Maryland | Montgomery Potomac 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 20854 8201 Lakenheath Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 XMarried "natural", or þ ☐ Yes 2 🛣 No Yes, Give Baltimore, Maryland 21215-0036 white 1 Yes 2X No Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n (Specify only highest grade completed) Lamination/Plaque Elementary/Seconday (0-12) College (1-4 or 5+) Company 5+ 0wner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jack Kraft Rosa Zwerner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 8201 Lakenheath Way, Potomac, Maryland Marcia G. Kraft, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 12/17/2010 Falls Church, Virginia 21. Signature of Funera Conce Licensee 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC.
1091 Rockville Pike, Rockville, Mary MO1255 Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Esophageal Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and -tr Due to (or as a consequence of): attending physician of for use as the burial Physician/Medical Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death Other (specify) signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an s certificate has birector, page 2 s prior to completion of cause of death? performed? 1 Yes 2 No Yes 2 🖵 No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director; to the funeral director; the funeral director; the funeral director; the funeral director; the function of the funeral director; the function of the funct 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural 5 Pending 1 Yes 2 No M Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) R143201

Registrar
DHMH 17 Rev 7/2009

State

Debra Miller, Muncaster Mill Way, Rockville, Maryland

3. Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 4:53 P.M Toros Kechichian S. December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Montgomery Rockville . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Davs Hours Min. (Month, Day, Year) Country) Lebanon Director 56 227-11-3350 Aug. Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 20874 <u> 19055 Steeple Place</u> United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11 Marital Status 14. Bace - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 K Married ☐ Yes 2 🕱 No 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3
Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Grocery Meat Cutter Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Eva Ajemian Sarkis Kechichian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19055 Steeple Place, Germantown, Maryland 20874 Hasmig Kechichian/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) 12/30/2010 | Germantown, Maryland Souls Cemetery ature of Funeral Service Lic 22. Name and Address of Facility DeVol Funeral Home East Deer Park Dr., Gaithersburg, MD. 10 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ulmonari ardiac disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury BI attending physician and for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a onsequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Other (specify) Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been funeral director, page 2 shoult 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes 2 4 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Hospital: 은 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending in 24 hours arter the Funeral Director, A Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Li Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the I only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 9 29d. Date signed (Month, Day, Year) 10 . m. D 00065505 December 25, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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Rockville, MD

20Y50

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day 2010 Physician/ Dec 0316 Edward Irving Kushner Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery 7024 Richard Drive Bethesda 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) **Funeral** New York (Month Day, Year) an 24, 1925 Days Hours 1 √x M 2 ☐ F 134-18-0471 85 Jan Director Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 😾 No MD Bethesda Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral "natural", or items 23a 20817 7024 Richard Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Battimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 ☐ Yes 2 🔀 No Specify. Specify: White If Yes, Give Completed 3 Divorced Year or Dates. WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Psychiatry 5+ Physician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Dorothy Cooper Bernard Kushner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6104 Overlea Rd., Bethesda, MD 20816 Doritt Carroll/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Dec 28, 2010 Atlantic Crematory ^{22. Name and Address of Facility}Thibadeau Mortuary Service, p.a. 7 Park Ave., Gaithersburg, MD 20877 Signature of Funeral Service Licensee M00956 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HIGH GRADE GLIOMA Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate outce. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trans and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Pregnant at time of death Yes 2 No the detached 9 Unknown g | Unknown is been signed by the should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? page 2 this certificate has 1 Yes 2 No eth. r After this certifica e funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No မှ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 5 Pending 1 Yes 2 No n 24 hours after det th. e Funeral Director A bleted filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Directo completed filled in by the determined Medical pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one 29d, Date signed (Month, Day, Year) 29b. Signature and title 12/ 27 10 + address of person who completed cause of death (Item 23a) (Type, Print) 15 ROCKHENGE

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 IRMANI 15 PM Physician/ 2010 Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner DR. MONT 8. Date of Birth (Month, Day, Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F 64 INDIA Director Heual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State injury or other traumatic event, the Medical Examiner must be notified at Director ROCKVILL Yes 2 No MD MONTGOMERY 10g. Citizen of What Country? 10e. Street and Number ò Funeral 20852 DRIVE AKISTAN FARMLAND 11502 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11, Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ASIAN 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) -INANCE ONOMIS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 KIRMANI SAL SISTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau DR. ROCKVILLE M.D. 20852 KHAWAJ 11502 FARML -AND AMNA KIRMANI 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 12/24/10 ADELPHI MD. GEORGE WASHINGTON 4 Donation 5 Other (Specify) 22. Name and Address of Facility ADEN MUS'LIM FUNERAL SER. 21. Signature of Funeral Service Licensee Ph EASYST. WOODBRIDGE VA-22191 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Physician/Medical Examin Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant: 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) a examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Certificate: To 2 💢 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 \(\sum \) Yes 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 🗆 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practice of the best of my worked (Check use and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signat Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Regis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Decedent's Name (First, Middle, Last)	_			2. Date of Death		3. Time of Death
	Physicia Medic		Cecil H. Lilly	y, Sr.			November	18 20°	10 2330 P M
1	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loc	ation of Death		4c. County of I	
Secretary.			103A Deerfield Road	(and bringly days)	E1kton	Under 24 Hrs.	8. Date of Birth	Ceci	Birthplace (State or Foreign
	Funeral Director		5. Social Security Number 236−36−0884 6. Sex 1 M 2 □ F 7. Age (In yrs. 84	Yrs.		ours Min.	March 30,	°1926	West Virginia
	nd now at	ž	Usual Residence of Decedent 10a. State 10b. County 10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	arylar a-fsl filed	Director	Maryland Cecil	E1kton					1 🏋 Yes 2 □ No
	or 28		10e. Street and Number		10f. Zip Code		10	g. Citizen of Wha	t Country?
	with s 23a ust b	Funeral	103A Deerfield Road		21921			United	States
	death items		11. Marital Status 12. Was Decedent Ever in U Argued Forces? Wor		Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Spec lexican, Puerto F	cify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
36	after II", or xamir	d by	1 Never Married 2 LA Married 1 LA Yes 2 L No If Yes, Give War	II	1 ☐ Yes 2 💢 No S	pecify:		Specify:	
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Maryland 21215-0036	e filec ed otl	To Be	17. Father's Name (First, Middle, Last) John Alfred Lilly		18.		<i>(First, Middle, Ma</i> ene McBr:	•	
ž	d Mel d Mel mark matic		19a. Informant's Name/Relationship (Type, Print)	10b Mailis	ng Address (Street and I				z Zin Codel
Ma	2 sho Ith an 27 is r trau		Betty Lilly/Wife		Deerfield				_
ē,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b.	Place of Dispo	osition (Name of matory or other place)	N - D	ate 2	0c. Location - Cit	ty or Town, State
<u>E</u>			1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.	A. Ferr	is & Co., Inc	Nover 19, 2	2010		Chester, PA
Baltimore,	permit. Departr Imports any inji	, ,,	21. Signature of Funeral Service Licensee	22	2. Name and Address of 103 W. S				erals, P.A. MD 21921
		Г	23a. Part LEnter the disease, or complications that caused the des shock, or heart failure. List only one call on each line.	ath. Do not ente	er the mode of dying, su	uch as cardiac or	respiratory arres	t,	Approximate Interval Between
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Вох	ath catternation	ician	in the past 12 months? 1 Live Birth 2 Fe	etal death 3	Ectopic pregnancy Other (specify)			Month	
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, P.O.	requires that the death certific been signed by the attending I should be detached for use as	by P	Part II. Other significant conditions contributing to death but not re	esulting in the u	underlying cause given i	in Part I.	23e. Did toba		ite to the cause of death?
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Division of Vital Records,	law has le 2	Completed by Physician/Medical					autopsy perform	prio ned? dea	or to completion of cause of
E	iician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?			of Death (Check		7	
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Sio	Attending or death. ector: After by the funer	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined						or Rural Route Number,
Div	tal or rs afte al Dire		4 — nonlicide determined building, etc. (Spec	rty) 		10	City or Town,	State)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my kno 2 Medical Examiner: On the basis of examinat	ion and/or inves	stigation, in my opinion, d	death occurred at	the time, date and	d place, and due to	the cause(s) and manner stated.
_	To the within 2 To the comple	2	29b. Signature and title of certifier		29c. License nu	ımber	29	9d. Pate signed (A	
9)		(lossegen MI)			x0756		111711	3
	4		30. Name and address of berson who completed cause of death (Ite	MO	223 (ion u	n St	5 (Kt	21,00
	Sta Registra		31. Date filed (Month, Day, Year) JAN 12 2011 32. registrar's Sign	ature .	arked				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:30 A^M DEC 2010 DESMOND LEWIS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav 5. Social Security Number 6 Sex (Month, Day, Year) **Funeral** Country)
TRINIDAD Months 1 🛛 M 2 🗆 F 79 Director 578-80-4961 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State Director 1 √ Yes 2 No PRINCE GEORGE'S HYATTSVILLE MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 20781 TRINIDAD 5400 SPRING LA. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 ☐ No Specify: 3 😾 Widowed 4 🗌 Divorced HISPANIC SPANISH Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) WELDER WELDING Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ SABALA LEWIS MARIA JOHN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5400 SPRING LA., HYATTSVILLE, MD. 20781 RONALD M. LEWIS/SON 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 X ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-29-2010 BRENTWOOD, MD. FT. LINCOLN CEMETERY 21. Signature of Funeral Service Licensee Name and Address of Facility
AMBERS FUNERAL HOME & CREMATORIUM, P.A.
01 CLEVELAND AVE., RIVERDALE, MD. 20737 M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death prostate lances Immediate Cause (Final 5+ Physician Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or linjury spital or Attending Physician: The law requires that the death certificate be executed ours after death.

leral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Place o Death (Check only one) 25. Was case referred to medica Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ANO 1 Npatient 2 ER/Outpatient 3 DOA ျှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Lectrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the classes, and mainten as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 2005 FP 81

12200 ANNAPOLIS RD. #229, GLENN DALE, MD. 20769

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31. Date filed (Month, Day, Year)

DEC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 8:15 P M December Eleanor Lesser Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Hebrew Home of Greater Washington 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Dec 23, 1917 Days Hours 1 ☐ M 2 ☐X New York **Director** 056-05-1598 93 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1

Yes 2 □ No DC NONE Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20008 USA 3001 Veazey Terrace NW, Apt 1111 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces' Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🔀 No Completed by Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ida Hahn Joseph Sertner 20008 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3001 Veazey Terrace NW, Apt.1111, Washington, DC Larry Lesser/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 K Burial 2 Cremation 3 X Removal from State Valhalla, New York Kensico Cemetery 1/2/2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityDanzansky-Goldberg Memorial Chape s 21. Signature of Funeral Service Licenses Michenni 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence o Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-trathat initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☑ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death a 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 🗌 Yes Records, HRO SCIERD SIS 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 has autopsy performe 1 ☐ Yes 2 ☐ No this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No 1 Tyes Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work Natural 1 ☐ Yes 2 ☐ No] Àccident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) ု 30. Name and address of person who completed cause of death (Item 23a) (Type, Pfrint)

Registrar

State

31. Date filed (Month, Day, Year)

28 2010

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2. Registrar's Sig

10-09790 Daniel Isaac Linden Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Certificate of Dea	ath	Reg. N	lo.	
Physician/	Decedent's Name (First, Middle,Last)			Date of Death Month Da December 19		3. Time of Death 0458 hrs
	4a. Facility Name (if not institution, give street and number		, Town, or Location of Death		4c. County of Death	
Funeral	Stoneybrook Park Field 5. Social Security Number 6. Sex 7. Ac		er Spring	s. 8. Date of Birth (M	Montgomery M/DD/YYYY) 9. Birth	place (State or
Director	218-19-9492 ₁ XM 2 F	· ` · · · · · · · · · · · · · · · · · ·	nths Days Hours Mir	,	1	MD
s us	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location				10d. Inside City Limits
Maryland 28a-f show d at once. ector	MD Montgomery	Silver Spri				1 Yes 2 X No
ith the Maryland 23a or 28a-f sho notified at once. al Director	10e. Street and Number	10f. 2	Zip Code		Citizen of What Count	ry?
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once ed by Funeral Director	4008 Delancy Drive 11. Marital Status 12. Was Decedent	t Ever in U.S. 13. Was Dece	20906 Ident of Hispanic Origin? (S	pecify Yes or No-	USA 14. Race - Americ	an Indian, Black,
or items 23	1 Never Married 2 Married Armed Forces' 1 Yes 2	? If Yes, spe	ecify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
ural", miner	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade cor		2XX No specify: al Occupation (Give kind of	work done 116t	Specify: Whit	
7 3 -1 7	Elementary/Secondary (0-12) College (1-4 or	during most of v	vorking life. DO NOT use ret		or Data to	
within giene. Her than Medic	12	Self-	Employed		Own Busine	:55
	17. Father's Name (First, Middle, Last) James Bernard Lindon		18.Mothers Name	e (First, Middle, Maid Carolyn	_{en Surname)} Ann Stover	
AD 2121: 2 should be fill h and Mental I 27 is marked imatic event,	19a. Informant's Name/Relationship (Type, Print)		ss (Street and Number or			
MD and 2 sho alth and em 27 is raumati	Carolyn Ann Lindon/Mother 20a Method of Disposition	20b. Place of Disposition (N	Delancy Driv		Spring, MD	
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and In Important: If trem 27 is n injury or other traumatic	1 Burial 2 Cremation 3 Removal from St		De De	c. 23,		
altirr nit. Pa vartmen oortani ury or	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22. Name a	nd Address of Facility is J. Collins		Alexandria	, VA
	Joseph P. Fotz Mois	500 טו	niversity Blv	d. W., Si	lver Sprin	
Physician /Medical	23a Fart I. Enter the disease, or complications that caused failure. List only one cause on each line.		e of dying, such as cardiac o	or respiratory arrest, s	shock, or heart	Approximate Interval Between Onset and Death
<u> </u> xaminer	Immediate Cause (Final disease or condition resulting in death) a. CONTACT GUNSNI Due to (or as a cons	ot Wound of Head equence of):				
<u> </u>	Sequentially list conditions, if any, leading to immediate b	aguana of\:				
Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated					
Example of the control of the contro	events resulting in death) Last Due to (or as a cons d.	equence of):				
760, cate be executed physician and the burial - transic	UNPENDED AMENDED					
8760 iffcate b ig physic rs the bur	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcomed to the sum of the line in the line	me of pregnancy 2 Fetal dea	th 3 Ectopic pregna		23d. Date of delivery Month Da	y Year
). Box 687 the death certific. by the attending p tiched for use as th	past 12 months?	time of death 5 Other (S				
D. BC tithe der by the a sched for Phys	Part II. Other significant conditions contributing to deat	h but not resulting in the underly	ng cause given in Part I.	23e. Did tobac	co use contribute to th	ne cause of death?
res that the signed by be detach				1 Yes 2	No 3 Proba	bly 4 🗹 Unknown
Records, The law requires ficate has been signed. Page 2 should be Completed				24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
Reco				performed 1 Yes 2		2 No
ital sician: s certif irector,	25. Was case referred to medical examiner?	ent 2 ER/Outpatient 3	26.Place of Death (Check		idence 6 🗸 Other:	Scene
Division of Vital Records, tal or Attending Physician: The law requires after death. a) Director: After this certificate has been siled in by the funeral director, page 2 should be reffication: To Be Completed	27. Manner of Death 28a. Date of Inju.	urv 28b. Time of Injury	28c. Injury at Work?	28d. Describe how Subject shot se	injury occurred	
Sion Mttendi death. ctor: / yy the fi	2 Accident Investigation Dec 19, 2010	0446 hrs	1 Yes 2 ✔ No			15
Division of spiral or Attending tours after death. Bours after death. Filled in by the function: Certification:	3 V Suicide 6 Could not be	njury - At home, farm, street, facto rk/Recreation Area	ory, office building, etc.	or Town, State	et and Number or Rura) et, Silver Spring, M	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn Medical Certification: To Be Completed by Physician/Medi	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examiner:	y knowledge, death occurred at	he time, date and place, and my opinion, death occurred	d due to the cause(s)	and manner as stated	i.
With To I	and manner stated,		9c. License number		d. Date signed (Mont	
12	29b. Signature and title of certifier	12	Sc. License number		a. 2 a. a a. g a - (11.0/11	ii, Day, rear/
3		and.	O.C.M.E. 00		ecember 19, 20	
12	29b. Signature and title of certifier Lodon M. Kry JA. 30. Name and address of person who completed cause of o	Jeath (Item 23a)	20	ME D		

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend item 8 per inf g912 2-7-11 vt. State of Maryland / Department of Health and Mental Hygiene | | | 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** M Esther Ann Leibowitz Dec. 19. 2010 10:45A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Potomec, Mary and
If Under 1 Year If Under 24 Hrs. 8. Date of 11 18 Min. Months Days Hours Min. Nov. 20, 11. Arden Courts Potomac Montgariery 1913 9. Birthplace (State or Foreign Country) 14 New York, NY 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 K F 96 Vrs 1914 Director 064-10-4064 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show event, the Medical Examiner must be notified at Yes 2□No Director MD Montgamery Rockville 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 7045 Wolftree Lane 20852 U.S.A · death v Funeral Items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours efter 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Is marked other than "natural", or 1 □Yes 2X No Specify: White Specify ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Publishing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be for and Mental I permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked i any Injury or other traumatic ev Adolf Leibowitz Anna Zuckman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Lowe- Executrix 7045 Wolftree Lane Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 □ Cremation 3 □ Removal from State Mount Judah Cemetery 4 □ Donation 5 □ Other (Specify) Dec. 20, 2010 Ridgewood, NY 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 20705 Borgwardt Funeral Home 4400 Powder Mill Rd. Beltsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Arrythmia Physician /Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) Ö been signed by the should be detached 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Š Vascular Dementia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 21 No certificate 2 No 1 □Yes 1 ☐Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Asst. Living 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral dir Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 14 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation after death, I Director: Aid in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral DI

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35579 Dec. 19, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan J. Miller, MD 8218 Wisconsin Ave. Ste. 305 Bethesda, MD 20814 31. Date filed (Month, Day, Year) 32 Registrar's Signatu State 27 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Lewis Lula 8:01 PM Medical DECEMBE 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 1206 KINGSBURY DRIVE PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Days Hours Min 577-52-6586 79 NORTH CAROLINA Director Usual Residence of Decedent or 28a-f show 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD PRINCE GEORGE'S BOWIE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20721 USA 1206 KINGSBURY DRIVE · death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 hours after **BLACK** 1 ☐ Yes 2X No 3 Widowed 4 Divorced Specify. Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed witl Department of Health and Mental Hygier Important: If item 27 is marked other 1 any injury or other traumatic event, the CTIVITY COORDINATOR PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ GLADYS ALLEN HERMAN H. HARRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANTONIA LEWIS-BROWN/DGT. 1206 KINGSBURY DRIVE BOWIE, MARYLAND 20721 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ALLEN FAMILY CEMETERY 12/27/2010 FUQUAY VARINA, NC 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21 Signature of Puneral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Lolon cancer Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last requires that the death certificate be executed and -tran Due to (or as a consequence of): attending physician at for use as the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 - Fetal death in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 XNo Division of Vital Hospital or Attending Physician: 25. Was case referred to-medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 1 🗌 Yes ျှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the fun 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ns.Rajapamem. D 12/22/10 DO057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar N.S Rajapakse, MID

31. Date filed (Month, Day, Year)

2835 Smith AV. 5-703

32. Registra 's Sign

Balt more MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra AMEND#8perFH, 12/28/10, EMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Flora 2010 Moder Medical December 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town or Location of Death 4c. County of Death Holy Cross Hospital Silver Montgomery 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Year)1921 1 DM 2 X F Months Days Hours Min. **Director** 89 117-18-4110 08/29/2010 New York Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Montgomery Silver Spring ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 12913 Moray Road 20906 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 ☑ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) it. Page 1 and 2 should be filed withintrent of Health and Mental Hygien rrant: If item 27 is marked other thiury or other traumatic event, the Science Scientist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jack Stark Fannie Simon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur Wolman / Son 20139 Club Hill Drive Germantown, MD 20874 Baltimore, Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🕅 Burial 2 🗆 Cremation 3 🕅 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Grdns 12/26/2010 Falls Church, VA David Mem. 21. Signature of Funeral Service licenses 22. Name and Address of Facility Danzansky-Goldberg Memorial C 1170 Rockville Pike Rockville Chapels Inc. Le, MD 20852 Blake Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Cardiac Arrest Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed <u>Hyperlipoproteinemia</u> and burial-trag resulting in death) Last Due to (or as a consequence of attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Live Ferance in the past 12 months?

1 Yes 2 X No Year signed by the a g Unknown g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Atrial Fibrillation Were autopsy findings available prior to completion of cause of death? 24a. Was an Interstitial Lung Disease has autonsy performed? Yes 2 No To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner: Hospital 2 X No မ 1 Inpatient 2 ER/Outpatient 3 X DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work?
1 Yes 2 No 5 Pending iniury Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Ovithin 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Mirse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying 29b. Signature and title of certiff 29c. License number 29d. Date signed (Month, Day, Year) December 22, 2010 D16495 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Old Georgetown Rd. Suite 104 Bethesda, MD 20814 0401 <u>Joel Goozh M.D</u> 31. Date filed (Month, Day, Year) 82. Registrar's Signature State 28 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ December Jean MacLeod 2010 Marjorie 5:37 A. Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. (Month, Day, Yearch 14. Year) Director 1927 Massachusetts 013-20-0750 83 March Usual Residence of Decedent 28a-f shov 10c. City, Town or Location within 72 hours after death with the Maryland must be notified at 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Germantown þ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 12125 Red Admiral Way 20876 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Medical Examiner Black, White, etc. ō ģ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify: Specify: White "natural" 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) other traumatic event, the Registered Nurse Nursing Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, h and Mental 7 is marked o ဂ္ McKenzie James MacLeod Jean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 <u> 2125 Red Admiral Way, Germantown, Maryland 20876</u> <u>Joseph MacLeod/Spouse</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1
Department of Important; If it any injury or o 1 🔀 Burial 2 🔲 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount St. Mary's Cem. 12/28/2010 Emmitsburg, Maryland 22. Name and Address of Facility DeVol Funeral Home ature of Funeral Service License 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death acute Immediate Cause (Final dysthy thmia Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Hospital: Other: 2 **N**No 1 Inpatient 2 XER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 5 Pending work? 1 ☐ Yes 2 ☐ No 1 📜 Natural ours after death.

eral Director: Ai
filled in by the fu Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature 29c. License number ρ D05388 ber 22,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive, Rockville, Many land Panitch WD 9901 Medical Center orlee 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Parke 28 2010 OEC Registrar

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DECEMBER

Acuedo

MARJORIE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23d, 25, 27, 28a-f per me g921 11-4-11 vt State of Maryland Department of Health and Mental Hygiene StateRegistrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day December 17, Robert Joseph Murphy 2010 7:35 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours (Month, Day, Apr. 27, 1**₹** M 2 □ F 1916 **Director** Yrs 138-18-6295 94 \mathbf{W} Usual Residence of Decedent or 28a-f shov perriit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Derartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Me Ical Examiner must be notified at one. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🖵 No MI Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5010 Euclid Drive 20895 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give 2 🗌 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 ★Widowed 4 □ Divorced Year or Dates. WII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Defense Intelligence Analyst Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Murphy Florence Perrine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5010 Euclid Drive, Kensington, MD 20895 Daniel J. Murphy/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State Date cemetery, crematory or other place) 1 🛣 Burial 2 □ Cremation 3 □ Removal from State ^{Dec}2010²¹ 4 ☐ Donation 5 ☐ Other (Specify) Cate of Heaven Cemetery Silver Spring, MD 21. Signature of Funeral Service Licens _22. Name and Address of Facility Francis J. Collins Funeral Home Inc 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician Cardiac Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER To the Hospital or Attending Physician: The law requires that the death certificate be executed Acute Renal Failure and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial by Physician/Medical Right Hip Fracture IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 🗌 No the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 🗌 No 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury noon watural 5 Pending work? 1 ☐ Yes 2 🗶 No 2 X Accident subject tripped and fell Investigation Dec. 16,10 12:00 M Suicide Could not be Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5010 Euclid Dr. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Kensington, home Md. Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 2+ ava 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tara M. Roque, MD 8600 Old Georgetown Road, Bethesda, MD 20814 31. Date filed (Month, Day, Year, Registrar's Signature State Registrar

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MURPHY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 15^{Day} 1226 Margaret Fitzpatrick Mullen 201^v0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Days Hours Min 1 □ M 2 🕱 F Months 08 08 PA **Director** 78 186-26-0521 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 H Yes 2 □ No Rockville MD Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 6121 Montrose Rd TISA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black If Yes, Give Year or Dates 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Logistic Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harvey Fitzpatrick Rebecca Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 198 Wallace Circle New Castle, PA 16101 Carol J. Barber/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Fort Lincoln Cemetery 12/23/2010 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Gastrointestinal Hemorrage disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner e attending physician and for use as the burial-transit Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 \(\subseteq \text{ Yes} \) 2 \(\frac{1}{2} \) No Pregnant at time of death
Unknown Month Day Year sate has been signed by the a page 2 should be detached to 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏝 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 24 No death? 2 X No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🕅 No 1 🗌 Yes Other: မ 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 1 🔄 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Fractioner: To the best of my knowledge, death of cutted at the time, date and place, and due to 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Atul Rohatgi, MD 8600 Old Georgetown Rd. Bethesda, MD 20814 31. Date filed (Month, Day, Year) Registrar's Sig State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 19 Physician/ Month Lomas McDowell 2010 3:16pM December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death P.G. Laurel Regional Hospital Laurel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year 1 🛣 M 2 🗆 F 75 Yrs. SC **Director** 238-42-0145 Oct 1935 Usual Residence of Decedent items 23a or 28a-f shov ner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director MD P.G. Forestville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2003 Ode Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iten ledical Examiner n 11. Marital Status Was Decedent Ever Armed Forces? 1 KX/es 2 \(\subseteq \text{No.} \) Black, White, etc 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Kures If Yes, Give Korean Year or Dates Conflict Specify: Black 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Chef Food Service permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Unknown Sally McDowell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Juanita V. McDowell/Wife 2003 Ode Road, Forestville, MD 20747 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date N Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Dec 28, 4 ☐ Donation 5 ☐ Other (Specify) De La Salle Cemetery Beltsville, MD 22, Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 . Signature of Funeral Service, Licensee Kehard F Kateo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Anoxic Encephalopathy Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and -trar Due to (or as a consequence of): the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Month Pregnant at time of death be detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page 2 After this certificate Yes 2 No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes _ 2 🏝 No Hospital: Other: ျှ 1x Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 5 Pending e Hospwan n 24 hours after death. he Funeral Director: Aft 1 XNatural Investigation Accident Suicide 6 Could not be To the Hospital or Atte within 24 hours after der To the Funeral Director completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 👿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifies (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D0067210 December 19, 2010 2+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rahit Khirbat, MD 7300 Van Dusen Road, Laurel, MD 20707 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month December 19 8:50 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Regional Hospita -aurel Prince 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 C 8 Date of Birth **Funeral** Months Days Hours Min. (Month, Day, 09 26 1 🔀 M 2 🗆 F SC **Director** 579-03-4415 96 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Prince George's Bowie 10e Street and Number ò 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 20720 6221 Gothic Lane USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 XYes 2 No3-1944 Black, White, etc. þ 1 Never Married 2 Married within 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates. Specify: Black Completed 3 Widowed 4 Divorced 12-1945 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Page 1 and 2 should be file nent of Health and Mental I ant: If item 27 is marked o မ Lewis McCombs Ophelia Gordon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Irene Douglas/Daughter 6221 Gothic Lane Bowie, MD 20720 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran's 01/04/2011 Cheltenham, MD Signature of Funeral Service Licensee Marshall-March Funeral Home 22. Name and Address of Facility 4217 9th St. NW Washignton, DC 20011 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Respirator Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PSis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to or as a consequence of): angrene that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page death? 1 ☐ Yes 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 X No ပ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify, 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending s after death.

Director: Aft
d in by the fur 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M 69347 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road 7300 Van Dusen Laurel Regional Mohamed Tourky, MD Hospital

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene 1 State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NORMA MURRAY 2153 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Poninsula Regional Medical Center Wicomico If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏋 F Months (Month, Day, Year) APRIL 15, Days Hours Min. MARYLAND Director 80 220-26-3589 Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location with the Maryland at 10d. Inside City Limits Director or 28a-f st notified 1 X Yes 2 No DELAWARE SUSSEX SELBYVILLE 10e, Street and Number 10f. Zip Code must be r ò 10g. Citizen of What Country? Funeral 47 LIGHTHOUSE ROAD 19975 filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. "natural", or iten ledical Examiner n 11. Marital Status 14. Race - American Indian Black, White, etc 1 Yes 2 X No δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 XWidowed 4 ☐ Divorced WHITE Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Ith and Mental Hygiene. 27 is marked other than traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 OFFICE MANAGER COUNTY GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ie 1 and 2 should be fil t of Health and Mental If item 27 is marked မ GEORGE Η. TRUITT BERNICE BALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOLORES L. MURRAY/EXECUTOR LIGHTHOUSE ROAD, SELBYVILLE, DE. 19975 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: If any injury or OLD SCHOOL BAPTIST CEM 12/31/10 SNOW HILL, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ De compen disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? this certificate Yes 2 1 🗌 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 400 Other: 1 Department 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier \mathcal{O}_{i} f person who completed cause of death (Item 23a) (Type, Print) m.D 100 F. PR.M.C Sad 31. Date filed (Month, Day, Year) Registrar's Signature State 29 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 10:00A M 22 <u>Gustavus Alonzo Miller</u> December 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 519 Hearn Lane Salisbury Wicomico Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, **Funeral** Year) Months Days Hours Min. 1X M 2 □ F 92 March 18, 1918 Jamaica, **Director** BWI 220-28-4599 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Wicomico Salisbury 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 519 Hearn Lane Funeral 21801 USA Items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married P. Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: δ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Wicomico County Board Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed wi f Health and Mental Hygier tem 27 Is marked other th 7th custodian of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ David Miller (Maiden Last Unknown) Rose 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie M. Miller/wife 519 Hearn Lane, Salisbury, Maryland 21801 Department of Healt Important: If item 27 any injury or other t Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Mem. Cemetery 101/03/2011 Princess Anne, Maryland Israel 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1213 Jersey Road - Salisbury, M.D. atri JOLLEY MEMORIAL CHAPEI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** na disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions ner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed Exami burial-tran Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical nse : IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. ed by the detached 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy Physician: The perform 1 ☐Yes 2 ☐ No 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home Pesidence 6 Other (Specify) 1 Yes 2√No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending 1 ☐Yes 2 ☐ No death. 2 Accident investigation the 24 hours after death Funeral Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 829 Salisbury, Maryland Eastern Shore Drive Mehta, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sylvia Anita James Moore 1715 hrs₩ ĩÿ, 2010 December 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year April 20, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 579-48-8711 77 Washington, D.C Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No **Burtonsville** Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20866 **United States** 13903 Carthage Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates **Black** 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Howard University Elementary/Seconday (0-12) College (1-4 or 5+) Radiologist Hospital 6 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Evelyn James Alexander Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13903 Carthage Circle; Burtonsville, Maryland 20866 Sheila Ann Moore (Daughter) 20a. Method of Disposition
1

Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Lincoln Memorial Cemetery Suitland, Maryland 21. Signature of Funeral Se 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.; 600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) FAILURE KESPIRATORY Due to (or as a consequence of) SEPSIS Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):

Ph sician/ Medical Examiner

Physician/

Medical

Examiner

Funeral

Director

or 28a-f shov notified at shov

ed other than "natural", or items 23a or event, the Medical Examiner must be

and Mental Hygiene.

permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev anse.

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Funeral

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Baltimore, Maryland 21215-0036

nding physician Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h

Division of Vital Records, P.O. Box 68760

edical Exam	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consected. PNEUMOT	quence of):			
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☒ Unknown	23c. If yes, outcome of pregn 1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3 🔲 Ectopi			23d. Date of delivery Month Day Year
by	Part II. Other significant conditions of NON ST-ELEVA					o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Completed					24a. Was an autopsy performed?	
Be (25. Was case referred to medical			26. Place of Death (Che	ck only one)	
To B	examiner? 1 Yes 2 No	Hospital: 1 Xinpatient 2	BR/Outpatient 3 □	DOA Other: 4 I Nursing H	lome 5 Residence	6 ☐ Other (Specify)
Certificate:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, facto fy)	ory, office	28f. Location (Street a City or Town, Sta	an <i>d Number or Rural Route N</i> umber, te)
Medical	(Check 2 Medical Exam	rsician: To the best of my know iner: On the basis of examinations are Practioner: To the best of m	on and/or investigation,	in my opinion, death occurred	at the time, date and pla	ce, and due to the cause(s) and manner stated.

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9901 MEDICAL CENTER DRIVE

29d. Date signed (Month, Day, Year)

2010

DECEMBER 21

ROCKVILLE MARYLAND

Registrar

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DEC 2 7 2010

BRIAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mi

32. Registrar's Senature

LARPENTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death lacke Physician/ December 18, 2010 12:30 A.M Medical Facility Name (if not institution, give street and number)

St. Thomas More Nursing and Rehabilitation Center 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Hyattsville Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 1948 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🗶 F Months Hours Director 579-66-5525 62 Washington, D.C 18 January Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 X Yes 2 🗆 No District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20018 **United States** 3041 Bladensburg Road, N. E. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married ò 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: **Black** Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) District of Columbia Elementary/Seconday (0-12) 12th grade College (1-4 or 5+) Teacher's Aide Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank Arnolds, Sr. Louise Delores Smith 19a. Informant's Name/Relationship (Type, Print) (Brother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20011 7058 Eastern Avenue; N.W.; Apt. 111; Washington, D.C. Marcellus Andrew Arnold 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Waldorf, Maryland Heritage Memorial Cemetery Synature Funeral Service Lepses 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final the woronani disease or condition Medical resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day

Physiciani Examiner

signed by the aid be detached to

has

certificate

funeral (

filled in by the

within 24 hours after death.

To the Funeral Director: After this

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Completed

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Certificate: To

Medical

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

in the past 12 m

						egnar	
1		ive	Birth	1 2		Fetal	dea
4	\Box F	red	nant	at t	ime	of de	eath

5 Other (specify) 9 Unknown

28b. Time of

Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of injury (Month, Day, Year)

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably known 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

1 Yes

25. Was case referred to medical examiner? 1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one) Other: 28c. Injury at

Nrsing Home 5 Residence 6 Other (Specify, 28d. Describe how injury occurred 2 🗆 No

(2 L Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Natural Accident Investigation 3 Suicide 4 Homicide 6 Could not be determined X Certifying Physician:

Medical Examiner: Of Certifying Nurse Practical Control of Certifying Nurse Practical Certifying Physician Certif

3

5 Pending

30. Name and address of person who completed cause o

27. Manner of Death

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Defer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certif

To th

29c. License number 6288

4922 LaSalle Road

Hyattsville, Maryland 20782

work?

29d. Date signed (Morith, Day, Year)

31. Date filed (Month, Day, State

29a. Certifier

only one)

32. Regis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear 2010 Morrison 4b. City, Town, or Location of Death 4c. County of Death Calvert <u>Huntingtown</u> 7. Age (In yrs. last birthday. 6. Sex If Under 24 Hrs. 8. Date of Birth 1 □ M 2 🏲 F Months Days Hours Min Yrs 81 09/08/1929 Takoma 10b. County 10c. City, Town or Location Calvert Huntingtown 10f. Zip Code 10a. Citizen of What Country? 20639 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 X No

Physician/ Рм Medical Wanda 4a. Facility Name (if not institution, give street and number) Examiner <u> 2811 Beach Drive</u> Social Security Number Birthplace (State or Foreign Country) **Funeral** Director 578-38-8114 Usual Residence of Decedent 28a-f shov 10a State 10d. Inside City Limits **Funeral Director** must be notified 1 X Yes 2 No MD 5 10e. Street and Number 23a 2811 Beach Drive filed within 72 hours after death "natural", or þ 1 Never Married 2 Married 1 Yes
If Yes, Give 1 ☐ Yes 2 No Specify: Specify Completed 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 12 Homemaker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Page 1 and 2 should be Paul Sellers Oma Simmers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Dawn Shamkin - Daughter 2811 Beach Drive Huntingtown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department of F Important: If ite any injury or ot once, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 12/23/2010 Brentwood Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral HOme, Inc Jorga Montgomey Cheatran 3401 Bladensburg Road Brentwood, MD 23a. Part 1. Writer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Acute Respiratory Failure Medical Due to (or as a consequence of) Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of). that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 2 🗌 No 1 🗌 Yes ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes ဥ 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Nesidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🛣 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours Funeral Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 23 minsh D00019427 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

For State Registrar

20678

Prince Frederick, MD

130 Hospital Road

MD

<u>Anwar Munshi</u>

DEC 2 8 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12/27/2010 3:45 A M EVERETT MOORE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S VILLA ROSA NURSING HOME MITCHELLVILLE If Under 1 Year | If Under 24 Hrs. **Funeral** Social Security Number . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🔯 M 2 🗆 F (Month, Day, Year) 4/25/1953 Director 578-70-7692 57 Wash, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 X Yes 2 No Maryland Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 4006 22nd Ave. 20748 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Black 3 ₩ Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important If item 27 is marked other than "natury no tuther traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Truck Driver Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Eldridge R. Moore Kathleen Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia M. Smith / Sister 4006 22nd Ave. Temple Hills, Maryland 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/4/2011 Riverdale Park Riverdale, Maryland Signature of Funeral Service U 22. Name and Address of FacilityPope Funeral Homes, P.A. MOIDS 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. (List only one cause on each lim. Interval Between Onset a Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to or as a con equence of) Examiner Securation leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 🗌 No ate has been signed by the a page 2 should be detached a 🗌 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: မ 1 🗌 Yes 2 No Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse-Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature title of certific 29c. License number 3226 2-28-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Feldman 8116 Good Luck Road Suite 300 Lanham, Maryland 20706

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Phillip Month Year Meilhammer 6:43 A M 12 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbu + the L Wicomico If Under 1 Year | Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours Min 08/12/1932 **Director** 214-28-8651 78 Wisconsin Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sh notified a 1 Yes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be r Funeral 303 Naylor Mill Road 21801 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: white Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) carpenter carpentry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Meilhammer Sr. Martha Market injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Anderson/daughter 28012 White Pond Dr., Salisbury, MD 21801 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Salisbury Crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 12 21 2010 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ANTIONAY FUNETAL Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ HE Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 NO 1 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No ဂ္ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? 2 🗌 No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Meil hammer

DHMH 17 Rev 7/2009

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

DEC

28

only one

Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year,

STERN SHORE DRI SALISBURY MI 2/804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For State	State of M	larylan		artmen <i>tificate</i>			and M	1		PAI	n.	1.5%	90
			Registrar 1. Decedent's Name (First, Middle, La	st)			uncate	OIL	Calli		2. Date of De	Reg. No.	. U 1	U	3. Time of	Dogth
	Physicia		, , ,	James Nic	kens		Month December						5. 20°	ar To	1:15	Р м
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30	ŕ		Holy Cro	ss Hospita	1			Silv	er Sp	ring	g		Mont	tgor	nery	
	Funeral		Social Security Number 6. S	Gex 7. Ag		st birthday)	If Under Months	1 Year Days	If Under		8. Date of Bir		9.		lace (State o	r Foreign
	Director		225-70-2050 Usual Residence of Decedent		59	Yrs.					July 27	7, 19	51	-	DC DC	
	und show at	'n	10a. State 10b. County		10c. City	, Town or Lo	cation							1	0d. Inside Ci	ty Limits
	//anyla 8a-f s tified	ect	Maryland Prince	George's				S	Suitla	and					1 🛚 Yes	2 🗆 No
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	is 23a	nera	5103 Silver Vall	ey Way				20%	746			U	nited	St	ates	
	death item ner n		11. Marital Status	12. Was Decedent Armed Forces?		. 13. V	Vas Deced	ent of Hi	spanic Orig	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)	1	4. Race - A			
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nd	filed tal Hy d oth	To Be	17. Father's Name (First, Middle, Last)						18. Mothe		e (First, Middle,		,			
χ	should be filed within 72 h and Mental Hygiene. 7 is marked other than " traumatic event, the Med	-		Edward Nic	kens					Ann	ie M.	Holla	ınd			
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be natified at once.		19a. Informant's Name/Relationship (1	** *	<u> </u>						Route Number Suitla					46
	f Hear item		20a. Method of Disposition		20b. Pl	Llace of Dispo	sition (Nam	ne of			Date		cation - Cit			
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	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Exam	sician: To the best of	examination	and/or invest	tigation, in n	ny opinio	n, death oc	curred at	the time, date a	and place,	and due to	the cau	ise(s) and ma	inner stated
	the	Me	only one) 3 Certifying Nur 29b. Signature and title of certifier	se Practioner: To the	best of my	knowledge, o	death occur	red at the	time, date	and place	e, and due to th	ne cause(s)	and manne	er as sta	ited.	
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DHMH 17 Rev 7/2009

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		For State Registrar	State o	f Maryland /		ment of H		nd Mental	Hygien	ZHIU	42591
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Funera Directo		104-16-4222	6. Sex 1 □ M 2 🔀 F	7. Age (In yrs. last bi		onths Days	Hours 24		th, Day, Year	9. Birth	nplace (State or Foreign ntry) York .
	9	Usual Residence of Decedent		09				Augu	36 3,	1721 110	WIOIR
land sho	ţō	10a. State 10b. County		10c. City, Tov	wn or Locatio	n					10d. Inside City Limits
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and	100	Joseph	Brenna	n			18. Mother	's Name <i>(First, M</i> Gar		Ashton	
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of He		20a. Method of Disposition		20b. Place	of Disposition			Date		Location - City or 7	
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		23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that cally one cause on each	aused the death. Do th line.	not enter the	e mode of dying	, such as ca	ardiac or respirat	ory arrest,		Approximate Interval Between Onset and Death
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The late has page	S							1 [performed? Yes 2 K		2 🗆 No
VITAI ysician: is certific director,	Be	25. Was case referred to medical examiner?	Hospital:					(Check only one)		
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DIVISION tal or Attendir s after death. I Director: Af	ĮĚ	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At home, f			100 2		tion (Street a	and Number or Run	al Route Number,
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lospit t hour unera	Medical		Physician: To the be								ted. ause(s) and manner stated.
the H hin 24 the F	Me	only one) 3 Certifying	Nurse Practioner: 1	o the best of my know		occurred at the	time, date a		e to the caus	e(s) and manner as s	stated.
수 꽃 6 ፩		29b. Signature and title of certifier	ignti	WD		29c. License				Date signed (Month,	
D '		find			(fin + D :		41162		Dec	ember 21	, 2010
		30. Name and address of person v Vinu Ganti, M.D	10.00				town.	Marvlan	nd 208	74	
St	ate	31. Date filed (Month, Day, Year)	32// Re	gistrar's Signature	4.4		,				
Regist	rar	OEC 287	2010 Ce	was A.	park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Doris Carroll Oster 28 8:15 PM 2010 Dec /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis HealthCare The Pines Talbot Easton 8. Date of Birth (Month, Day, Year) Feb. 2, 19 If Under 1 **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 X F Months Days Hours Min. 215-18-4239 87 Maryland Director 1923 Usual Residence of Decedent 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Talbot Easton the 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 700 Port Street 21601 IISA Funeral Pages 1 and 2 should be filed within 72 hours after death whent of Health and Mental Hygiene. snt: If Item 27 is marked other than "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ∐Yes 2 Mino If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed by Specify: White 3 X Widowed 4 ☐ Divorced Item 27 is marked other than "nature other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Charles Franklin Carroll Margaret Payne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte S. Nickerson/Daughter 3925 Willey Road, Hurlock, Maryland 21643 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of IImportant: If ite
any injury or ot 1 X Burial 2 Cremation 3 X Removal from State 4 □ Donation 5 □ Other (Specify) Oak Hill Cemetery 1/5/2011 Lake Placid, Florida 21. Sign, tyre of Funeral Service/Lines 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 20d. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) propostive **Physician** wours /Medical Due to (or consequence of): Examiner years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician; The law requires that the death certificate be executed MOMS and burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physiclan for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year signed by the a 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Maire 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should I Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe Division of Vital 1 Yes 2 No 1 ☐Yes 2 ☐No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28h Time of 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident ours after death.
neral Director: A
filled in by the fu death. 1 ☐Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (BONTEL mn 610 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 29 Registrar

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10-09682 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. David Anthony Powell State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Medical Examiner POWELL 0210 hrs ANTHONY December 16, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's NB Laurel Bowie Road and Muirkirk Road If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Country) Director Hours 1X M 2 F MARYLAND Yrs 28 1986 24 NOV. 218-15-0550 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No PRINCE GEORGE'S BOWIE 28a-f show MD Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f she ye other traumatic event; the Medical Examiner must be notified at once Director 10f. Zip Code 20721 10e. Street and Number 10g. Citizen of What Country? USA 957 WESTLAKE DRIVE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes BLACK Divorced f Yes, Give Year 1 Yes 2 X No specify: Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7. PRIVATE 12TH MECHANIC 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be BRENDA ELLIS PROFFECOR POWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 957 WESTLAKE DRIVE BOWIE, MARYLAND 20721 BRENDA BRACY/MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State crematory or other place) Department of Im. ortant: 12/28/2010 LANDOVER, MARYLAND HARMONY CEMETERY Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Furnial Service Licensee J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): executed attending physician and or use as the burial - tran Physician/Medical UNPENDED AMENDED The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Fetal death Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the a Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been a d director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of . death? performed' 1 🗸 Yes ✓ Yes 2 No To the Hospital or Atteoding Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) æ Hospital: 1 Other Nursing Home 5 Residence 6 🗹 Other: Scene Inpatient 2 ER/Outpatient 3 1 Yes 28a. Date of Injury FOUND: Day,Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Driver auto fixed object collision 1 Natura FOUND 5 Pending 1 Yes 2 ✔ No Dec 16, 2010 0147 hrs 2 🗹 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) NB Laurel Bowie Rd. & Muirkirk Rd., Laurel, MD determined (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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31. Date filed (Month, Day, Year, State Registrar

29b. Signature and title of certifie

Carol Allan, MD

2

a

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

December 16, 2010

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $\overset{\mathsf{Day}}{1} \underline{9}$ December 2010 Saxton Parker Arthur 9:40 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chesapeake Woods Center Dorchester Cambridge 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth
(Month, Day Year)
Sept. 19,1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Days Min. Hours 219-03-0539 Maryland Director Yrs. ,1919 Usual Residence of Decedent "natural", or items 23a or 28a-f shov permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Me and Examiner must he moviting at 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Dorchester Cambridge 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Shady Drive 21613 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Force Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 🗓 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) chiropractor health care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Harry Elza Parker Lucy Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Parker 6 Shady Drive, Cambridge, MD wife 21613 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem 12/27/10 Hurlock, MD Signature of Funeral Service Licensee Thomas Funeral Home P.A. 22. Name and Address of Facility 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ pneumonia disease or condition Medical resulting in death) Examiner VSDIastic Sequentially list conditions, if a y, leading to himselfate cause. Enter Underlying Examiner (or as a consequence of) burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be et thours after death.
Funeral Director: After this certificate has been signed by the attending physicia Box 68760 as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown 9 Unknown ate has been signed by the page 2 should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by heart tailure, Division of Vital Records, anemia 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 Yes the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ဂ္ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation М 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

Bramble St

ddress of person who completed cause of death (Item 23a) (Type, Print)

100

32. Registrar's Signature

lohnson

31. Date filed (Month, Day, Year)

Ple

ease Type or Print in Black Indelible Ink. Ensur	e All Copies Are Legible.
State of Maryland / Department of Health a	nd Mental Hygiene
Certificate of Death	Reg. No.
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Physician
/Medical
Examiner

Funeral Director

per nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Imp. rtant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventher must be notified at once. Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital of Attending Physician: The law requires the Seath certificate be executed

within 24 hours after death.

To the Funeral Director: Inter this certificate has been signed by the attending physician and completely tilled in by the uneral director, page 2 should be detached for use as the burial-transit 2

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mine	-	4a. Facility Name (If not institution	n, give street and numbe	r)		4b. City,	Town, or	Location	of Death		4c. County of Death			
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ral		5. Social Security Number		Age (In yrs. i	last birthday)	If Under Months	r 1 Year Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Birt (Month, Day	h v. Yea	r)	9. Birth	place (State or Foreign intry)
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	으	Alexander Bungo 19a. Informant's Name/Relations			105 14-15		/C4+==4 =		cy Me	al Route Numbe	- Cit	ras Taura C	Note 7	in Cadal
5						•	•							, MD 20886
		Monica Cimino 20a. Method of Disposition	(Daughter)							Date		Location - C		
5		1 ☑ Burial 2 ☐ Cremation		e	Place of Dispo emetery, cren			i					•	
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	ä	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 🗆 Fetal	Ideath 3	Ectopic p						23d. Date Mon		Day Year
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	g	3 ☐ Suicide 6 ☐ Could	not be	niury - At ho	ome farm str					28f Location /9	Street	and Numbe	r or Ru	ral Route Number,
		4 ☐ Homicide determ	building,	etc. (Specif	y)		,,			City or Tov	vn, Sta	ate)	, 0, 110	arribato rambor,
	2	29a. Certifier 1 Certifyir	ng Physician: To the be	st of my kno	wledge, deat	h occurred	at the tim	ne. date :	and place.	and due to the	cause	e(s) and mar	nner as	stated.
:	Medical Certification: 10 Be Completed by Physician/Medical		Examiner: On the basis and manner	of examina										
	Me le	29b. Signature and title of certifie				29	c. License	number			29d. [Date signed	(Month	n, Day, Year)
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	-	30. Name and address of person	who completed cause or	death (Item	n 23a) (Type.	Print) 2	01	RU	5584	LAVE	· N	ue		
		30. Name and address of person A DOBERT E	birse HBAC	H, U	M.	2	141	142	ELSB	URG, M	14	120.	877	7
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day} 26. 2010 Marion Delane Powell Jr. December 9:39 РМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 8501 Schultz Road Clinton 8. Date of Birth (Month, Day, Year) Sept 25, If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 X M 2 🗆 F Director Yrs Sept. 1969 DC 579-08-1722 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 X Yes 2 No Clinton Maryland Prince George's ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 8501 Schultz Road 20735 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc o, þ 1 Never Married 2 Married 2 X No 1 ☐ Yes : If Yes, Give 1 ☐ Yes 2 X No Specify: African Specify: "natural" Completed 3 - Widowed 4 - Divorced Year or Dates American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than, Elementary/Seconday (0-12) 12th College (1-4 or 5+) the Driver Self-Employed other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked of traumatic even ၉ Marion Delane Powell Sr. Emma Mae Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Clinton, Maryland Crystal Powell - Wife 8501 Schultz Road item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Page 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State January 6, Important: If any injury or once, Landover, Maryland ☐ Donation 5 ☐ Other (Specify) Harmony 2011 22. Name and Address of Facility Stewart Funeral Home, 21. Si value of Funeral Service Licen 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Ph sician/ Metastatic Pancreatic Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Examine Due to (or as a consequence of): bunial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year ed by the a 9 Unknown s been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🛂 No ၣ 1 🔲 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Director: After 1 🔀 Natural 5 Pending 2 Accident filled in by the Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Division of Vital Hospital within. 2

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

State Registrar

6104 Old Branch Avenue Temple Hills, Maryland Eunice Shakir MD 31. Date filed_(Month, Day, Year) 32. Registrar's Signature JAN 0 3 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

3650

20748

Frances 32010 Parish December /Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner tincessAnne Manor If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🛛 F Director 94 11-30-1916 Usual Residence of Decedent 10b. County 10c. City, Town or Location show in than "natural", or items 23a or 28a-f sho Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a by Funeral 27943 Nanticoke Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 4 Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Feances ပ Raymond G. Parsons Stella 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21853 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health as
Important; If item 27 Is
any injury or other trau William Majors, Jr. - Nephew 27499 Mt. Vernon Road, Princess Anne, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parsons Cemetery 12-29-2010 | Salisbury, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Preumonia /Medical Due to (or as a consequence of) Examiner Dementra Sequentially list conditions, if any, leading to immediate cause that it is a cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 MNo 5 ☐ Other (specify) cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? perform certificate rmed? 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🜠 No Other: 4☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Day, Year)

1. Decedent's Name (First, Middle, Last)

Physician

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Day

Year

Black, White, etc.

West

1 ☐Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

12-24-10

White

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

Maryland

3:20PM

To the Hospitar ... within 24 hours after death. To the Funeral Director: After managed in by the further than the further th 10 m

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Division St. Salisbury, MD 21804 32. Registrar's Signature

168222

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

Registrar DHMH 17 Rev 1/2001

State

After this

27. Manner of Death

1 Natural

2 Accident

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DEC

3 ☐ Suicide

29a, Certifier (Check only 5 Pending investigation

6 ☐ Could not be

determined

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra AMEND#20boerFH, 12/29/10, EMW, MoCo Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:20 рм Anna Buonviri Quick December 2010 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens at Riderwood Silver Spring P.G. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours April 1 1 M 2 X Min Director 579-01-7068 95 1915 DC Usual Residence of Decedent 28a-f show 10a, State hours after death with the Maryland be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery 1 Yes 2 XX XX o Silver Spring 10e. Street and Number P 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a the Medical Examiner must b Funeral 3112 Gracefield Road, PV 521 20904 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 XNo Maryland 21215-0036 1 Yes 2 No Specify White Specify: Completed 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Clothing 12 Seamstress filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked or traumatic ever pe Saverio Buonviri t. Page 1 and 2 should be tment of Health and Mer tant: If item 27 is mark jury or other traumatic Concetta Del Casale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Pearce/Niece 4317 Mt. Olney Lane, Olney, MD 20832 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 28 20c. Location - City or Town, State Department o Important: If any injury or 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State De810²⁹ Hivet Cemetery 4 Donation 5 Other (Specify) Washington, DC Signature of Funeral Sc 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W., Silver MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or conditi-resulting in death) Chronic Obstructive Pulmonary Discase unknown Medical Due to (or as a consequence of) Examiner Securantially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): signed by the attending physician and dedetached for use as the burial-franct To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Advanced Dementia 1 Yes 2 No 3 Probably 4 Nown Completed peen . Were autopsy findings available prior to completion of cause of 24a. Was an No the Insertion after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2: autopsy performed?

I □ Yes 2 ☑ No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2XX No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🔀 Natural injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident
3 Suicide
4 Homicide Accident Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 3 who completed cause of death (Item 23a) (Type, Print) Eileen Gemmell, CRNP 3160 Gracefield Road, Silver Spring,. 31. Date filed (Month, Day, Year) Registrar's Signa State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Nancy Ruark Robbins December 19 2010 7:05 a.M /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Mallard Bay Care Center Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 21 F 220-32-0123 Director 76 27, 1934 Marvland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination at 10d. Inside City Limits MD Dorchester Director Crapo 1 ☐ Yes 2 🛱 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3118 Robbins Road 21626 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) owner/operator h and Mental Hygie seafood 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ould be fi Mental H permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev Horace Ruark Sue Ruark ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia L. Jones daughter 3324 Woodland Acre Rd, East New Market, MD 21631 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sandy Island Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 12/23/10 Robbins, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature o Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Se psis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any leading to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ■ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ heumatoid 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Physician: The law 24a. Was an has autopsy performed? Yes 2 24No certificate 1 □Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After t 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 🗌 No within 24 hours after death To the Funeral Director; filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier neen

State Registrar

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Box 68760.

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Division of Vital Records,

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Registrar's Signature

100

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Aurelia Anna Ryan December 2010 1:40 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Davs Hours 123-30-2909 Director 89 Aug. Italv Usual Residence of Decedent shov 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location with the Maryland Director r 28a-f sl notified 1 X Yes 2 □ No MD P.G. Laurel 10f. Zip Code 10g. Citizen of What Country? ō 10e Street and Number ms 23a or must be n Funeral 14243 Greenview Drive 20708 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status "natural", or iten edical Examiner r Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates Specify: White 1 Yes 2 No Specify: Completed 3 x Widowed 4 ☐ Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) . Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Federal Government 4 <u>Finance</u> other Be Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೨ Andrea Marusic Marta Unknown 19a. Informant's Name/Relationship (Type, Print)
Ersilia Lappa/Personal Rep. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3312 Chiswick Court, #3A, Silver Spring, MD 20906 and 2 sl Health 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20b. Place of Disposition (value of competery crematory or other place)

Arlington Nat'l Cemetery 12/29/2010 Date 1 Burial 2 Cremation 3 Removal from State Arlington, VA 4 Donation 5 Other (Specify) 21. Sign vuri of Funeral Service Lice _22. Name and Address of Facility.
Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ weeks disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of): Examiner End-Stage Alzheimer's Dementia vears Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No ō Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Acute Respiratory Failure, Coronary Artery Disease, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diastolic Heart Failure autopsy certificate has performed? Yes 2 No page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 →No မ 1 Hnpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending after death. Director; Af 1 ☐ Yes 2 ☐ No Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical

upleted filled in by e Funeral I

29a. Certifier (Check

29b. Signature and title of certifier

Burbara

31. Date filed (Month, Day, Year)

Barbara Supanich, RSM MD

28 2010

Suparuch 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D 0065485

1500 Forest Glen Road, Silver Spring, MD 20910

29d. Date signed (Month, Day, Year)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Time of Death 7:45 a ^M

			Decedent's Name (First, Middle, Last)						Date of De	eath		3. Time of Dea	ıth
	Physicia		Irene S. Rubenstei	n		December 16, 2010 7:45 a							
-	Medic Examir		4a. Facility Name (if not institution, give str	eet and number)		4b. City, Town, or Location of Death 4c. County of Death						1 1145 4	
			531 Randolph Road,	307B			Silver S	pring			Montgomer	7	
	Funeral		5. Social Security Number 6. Sex	7. Age (/	n yrs. last birtho	day)	If Under 1 Year Months Days	If Under 24 H		rth	9. Birthr	lace (State or For	reign
	Director		578-12-2046	M 2X□ F	97 Y	rs.	nonths Days	Hours M	in. 09/21/	191	3 Wash	ington,	DC
1	d how] _	Usual Residence of Decedent 10a. State 10b. County	1.	0- 0" T-								
-/-	-f sh ed a	턍			0c. City, Town	or Locat	lon				1	0d. Inside City Lir	
	Mar 28a notiffi	Director	Maryland Montgomer	y S	Silver	Spri						1 X Yes 2	_ No
	th the	a	10e. Street and Number				10f. Zip Code			10g. C	try?		
	th wir	Funeral	531 Randolph Road,					<u> 20904–5</u>			USA		
	r dea		11. Marital Status 12 1 □ Never Married 2 □ Married	Was Decedent Eve Armed Forces?			s Decedent of Hi es, specify Cuba		(Specify Yes or No- erto Rican, etc.)		14. Race - America Black, White, 6		
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Mary do Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by	3x Widowed 4 □ Divorced	1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates.)	1 [Yes 2 No	Specify:			Specify: Wh	lte	
5-	2 hou "nat	Completed	15. Decedent's Educ (Specify only highest grade		16a. E	Deceden Give kin	it's Usual Occupa d o <i>f work</i> do <i>n</i> e d	ation uring most of v	vorkina		Kind of Business Inc		
2	hin 7. ne. than	E	Elementary/Seconday (0-12)	College (1-4 or 5+)	Ìi	fe. DO I	VOT use retired)	annig mest er i	· ····································		ajor Washi rea Newspa		
2	d wit tygie ther nt, th	ம	12		Jou	rna]	ist					ther	
anc	ntal h	To B	17. Father's Name (First, Middle, Last)						Name (First, Middle,		,		
ž	uld b d Mer nark natio		"unknown" Solomon						wn" Lieb				
Ma	d 2 should be alth and Menti 27 is marked r traumatic e		19a. Informant's Name/Relationship (Type	· · · · · · · · · · · · · · · · · · ·	19b/ Ç/	Mailing /	Address (Street a	nd Number or hman At	Rural Route Numbe torneys	er, City o	or Town, State, Zip C ethesda, N	ode)	
e, L	and Health		Jeffrey Kolender, 20a. Method of Disposition	personal 1	20b. Place of D			Lane, /					
סר	nt of nt of t: If it		1 🛣 Burial 2 🗌 Cremation 3 🖼 Re	emoval from State	Washer	cremat	ory ar other place	e)	Date		Location - City or To	wn, State	
量。	it. Pa irtme irtani njury		4 Donation 5 Other (Specify)		Cong. 1	Memo	rial Pa	rk 12/	19/2010		shington,		
	permit. Page 1 and Department of Healt Important: If item any injury or other once.		21. Signature of Funeral Service Licensee	MO12	255	EDW 109	ARD SAG 1 Rocky	SOT FACILITY EL FUNE ille Pi	RAL DIRE	CTIC	ON, INC. Le. Maryla	ınd 208'	52
			23a. Part . Enter the disease, or complice shock, or heart failure. List only one	ations that caused th	e death. Do no							Approximate	
si.	Physician/		Immediate Cause (Final		to Hoom	4 TZ -	47					Interval Between Onset and Death	
	Medical		resulting in death)	Congestiv	onsequence of)	L Fa	liture						
	Examiner		Conventially list conditions	Respirato	ory Dis	tres	ss						
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co									
	cuted nd ransii	cam	Cause (Disease or linjury that initiated events c.										
	ath certificate be executed attending physician and for use as the burial-transit	Ê	resulting in death) Last	Due to (or as a co	onsequence of)	:							
00	te be nysici ne bu	dica	d.										
ox 68760	tifica ng pl	cian/Medical	IF FEMALE:										
9 ×	tendi r use	an/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of p 1 Live Birth 2	pregnancy Fetal death	3 □ E	ctopic pregnancy	y			23d. Date of delive	*	
Bo	deat he at led fo	/sic	1 Yes 2 XNo	4 Pregnant at tir 9 Unknown	me of death	5 🗆 C	ther (specify)				Month	Day Year	
P.O.	at the	Physi	Part II. Other significant conditions contr		not resulting in	the und	arlying cause give	en in Port I	oo- Pida				
σ.	es tha	þ	Tarkin Strict significant contains some	localing to death but i	not resulting in	trie dire	onlying cause give	orrirr arci.			use contribute to the		
<u>rd</u> s	equin een s nould	Completed							_	Yes 2	No 3 ☐ Prob	ably 4 \square Unkn	own
00	law renas b	nple							24a. Was auto	psy	24b. Were autop prior to con	sy findings availa opletion of cause	ble of
æ	The	S							1 🗌 Yes	rmed? 2 ☑ N	death?	2 🗆 No	
ta	cian: ertific ector,	Be	25. Was case referred to medical examiner?	spital:				ce of Death (C	heck only one)				
<u>=</u>	Physician: The lav r this certificate has rral director, page 2	10	I □ Yes 2 L X NO	1 U Inpatient	2 ER/Outp			4 L Nursing			6 Other (Specify)		
0	ing F	ate	27. Manner of Death 1 🔀 Natural 5 🗌 Pending	28a. Date of injury (Month, Day, Y	ear) 28b. Tin		28c. Injury work		28d. Describe h	now inju	ry occurred		
<u>0</u>	tend death tor: /	tific	2 Accident Investigation 3 Suicide 6 Could not be	00 - 51 (1-1	1111			Yes 2 ☐ No					
Division of Vital Records,	or Ai after Direc in by	Certificate:	4 Homicide determined	28e. Place of Injury building, etc. (S		ı, street,	factory, office		28f. Location (S City or Tov		nd Number or Rural i e)	Route Number,	
Ω	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 XCertifying Physicia	n: To the hest of my	knowledge de	ath occ	ured at the time	date and place	and due to the an	use/s) c	and manner as states		
	Fun eted	Medical	(Check 2 Medical Examiner only one) 3 Certifying Nurse F	: On the basis of exan	nination and/or i	nvestiga	tion, in my opinior	n, death occurre	ed at the time, date a	and place	e, and due to the cau	se(s) and manner :	stated
	To the vithin To the complete	2	29b. Signature and attle of certifier	ractioner: to the bes	a or my knowied	aye, uea	29c. License		piace, ainu que to th		(s) and manner as sta ate signed (Month, D		_
) (Jah.	m				028			4c, 17,		
	10		30. Name and address of person who com		h (Item 23a) (Tu	pe. Print		0 00			- ' ')		
						,	,						

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Carol Salzman, MD, 5530 Wisconsin Ave, Suite 800 Chevy Chase, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 16<u>,2010</u> 11:15 A.M Sally Oberstein Richter December Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Rockville Hebrew Home of Greater Washington 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🙀 F Days Hours New York . 1919 Director 113-09-2709 Usual Residence of Deceden ıral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rockville MD Montgomery 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6121 Montrose Road 20852 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes 2X No Yes, Give Specify: White 27 is marked other than "natural", traumatic event, the Medical Exar 1 Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Secretary 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) - should be fil. th and Mental h ဂ Samson Oberstein Elizabeth Van Daelen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health i 2251 Eisenhower Ave. #517, Alexandria, VA 22314 Elizabeth Richter/Daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State George Lown University Washington, D.C. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. mature of Funeral Service Lice /M009699013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each li Immediate Cause (Final disease or condition Onset and Death Physician/ neumonia Medical resulting in death) Examiner KNOWN Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death signed by the a Id be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig 2/No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 200 Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) nin 24 hours after death.

the Funeral Director: After this

npleted filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 3 Suicide 5 Pending 1 Yes 2 No Μ Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the Comple only op 29b. Signa all 30. Name and address of person who completed cause of death (Item 23a) (Type Print) 6121 MONTROSE

Registrar

31. Date filed (Month, Day, Year)

DEC 20 ZUIU

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Dec. 23, 2010 Ricciardella 6:17 pM Antoinette Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4h City Town or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min (Month, Day Director 170-26-6783 76 1934 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location notified at 10d. Inside City Limits Director MD Montgomery Brookeville 1 Yes 2 XI 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Examiner must be Funeral with 23a 2303 Honeystone Way 20833 USA items ; within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedon 2. Armed Forces?

1 ☐ Yes 2X No Black, White, etc. 9 by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 and Mental Hygie is marked other Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. John Krawcion Pauline Smetana 19a. Informant's Name/Relationship (Type, Print) -Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Pasquale Ricciardella 4301 Knowles Avenue, Kensington, MD 20895 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 2010 30, 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W., Silver Signature of Funeral Service Licens Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ¬Ph sician/ Cardiopulmonary Arrest disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): Cardiomyopathy, Ischemic Sequentially list conditions, Examine cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Congestive Heart Failure Cause (Disease or iinjury that initiated events burial-tra Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ ō in the past 12 months? 1 Yes 2 No Month the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Diabetes, Hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page After this certificate 2 No 1 ☐ Yes 2 ☐ No Yes he Funeral Director: After this certific pleted filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 2 No Other: 1 Yes Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 💆 Natural 5 Pending iniury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: Quihe basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner. To the best of my knowledge, do 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

1500

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ele

Negas

31. Date filed (Moner, Day, Year

D055856

ovest Glen Rd. Silver Spring, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Day 21, Physician/ Gertrude Marie Ryan 2010 10:45 p M December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Hospice-Casey House Montgomery Derwood Social Security Number 6. Sex Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 M 2 XF Months Days Hours Min. 79 Yrs Director 144-24-0836 1931 Sept. NJ Usual Residence of Decedent show with the Maryland Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director or items 23a or 28a-f 1 🗌 Yes 2 🖾 No MD Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4008 Wexford Drive Completed by Funeral 20895 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner musonce. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify. Specify: White 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Homemaker</u> Own Home Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Morley ဂ္ Mary Flatley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Edward Ryan/Husband 4008 Wexford Drive, Kensington, MD 20895 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Dec. 24 Silver Spring, MD Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Signature of Famous 5 framens^{Adgess} Collyins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Scleroderma Physician/ disease or condition resulting in death)) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): s the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ρ in the past 12 months?
1 Yes 2 No Pregnant at time of death Other (specify) Month Day Year been signed by the should be detached 9 Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (S 1 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Yes 2 No Accident Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) within To the 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) D37142 Dec. 22, 2010

Registrar

30. Name and add

Coleman,

31. Date filed (Month, Day, Year,

MD

2010

1355 Piccard Drive, Rockville, MD 20850

ress of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ Molly W. Roche 1:55рм 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Rockville Nursing Home Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
New York 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🕱 F Months Days Hours 087237 1975 Yrs Director 070-05-5069 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland nand Mental Hygiene. • is marked other than "natural", or items 23a or 28a-f shor 10a, State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 1 No Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7705 Persimmon Tree Lane 20817 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. <u>ک</u> 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 X Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Management Analyst U.S. Government - HUD traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sam Wexler Ida Loonsk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 si ment of Health a tant: If item 27 is Laurence Groner - Son 7705 Persimmon Tree Lane, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o cemetery, crematory or other place 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cing David Mem. Grdns 12/27/2010 | Falls Church, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD20904 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the diseas shock, or heart failure. Lis Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Coronary Artery Disease Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed an that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🗓 No Month Day Year Pregnant at time of death been signed by the should be detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Dementia Completed 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? Yes 2 A No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 X No Other: ပ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Leef D0064624 December 26, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sandeep Sharma, 743 Summer Walk Drive. Gaithersburg. Maryland 20878 M.D., 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiené Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9:55a M Florence Adeline Robinson December 24, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Center Gaithersburg Montgomeru Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 88 577-66-3413 Director 02/07/1922 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location ed other than "natural", or items 23a or 28a-f show event, the Wedical Example of the notified at 10d. Inside City Limits Director 1 ☐ Yes 2 🛛 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 Russell Avenue, Apt. #439-A Funeral 20877 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{X} \) No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. i lo 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No þ Specify. Specify: 3 X Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Manager 12 D.C. Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Mental H 7 is marked of traumatic ever Viola Blakeu George W. Hill ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Department of Health Important: If item 27 any Injury or other tronce. Carl C. Robinson - Son 1606 Via Corona, La Jolla, California 92037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) Entombrent Cedar Hill Cemetery 12/30/2010 | Suitland. Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) VCZCS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): e attending physician and ad for use as the burial transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 s autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 1 ☐Yes 2 ☐No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Mann of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation death. neral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after 4 ☐ Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) December 24 2010 30. Name and address of person who completed cause of death (Item 23a) Type, Print

Town 100 105 Ku MO 11 Pussel Ave Gzithersburg 31. Date filed (Month, Day, Year) 82. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

10-09978 Young Ro

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

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10-09979 Jae Bong Ro

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		Registrar		Certific	cate of	Death			Reg. No.			
Physici	an/	1. Decedent's Name (First, Midd										
Medical Exam		Jae Bong 4a. Facility Name (if not institution		(mb no)	1.6	City Town and	and the set Death		Day Yea er 26, 2010	0130 hrs		
,		Southbound Route# 2			41	o. City, Town, or Lo Laurai	ocation of Death		4c. County of Prince G			
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last b	irthday)	If Under 1 Year	If Under 24Hrs	. 8. Date of B	irth(MM/DD/YYYY	9. Birthplace (State or		
Director		214-78-8272	1 ½ M 2 F	67	Yrs.	Months Days	Hours Min.	09/08	3/1943	Foreign Country)Korea		
any		Usual Residence of Decedent 10a. State 10b. County	 .	10c. City, Tow	n or Locatio	n				10d. Inside City Limits		
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and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho trammatic event, the Medical Examiner must be notified at once.	Director	2413 Mill H	oiahta F	\rivo		10f. Zip Code	1		10g. Citizen of Wh	at Country?		
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Should Martic a	٢	19a. Informant's Name/Relations		- 0					mber, City or Town			
MD and 2 she salth and 2 is 27 is raumati		Young Soon 20a. Method of Disposition	Ro Sp	ouse 2	413	Mill He	ights			VA 20171		
of He		1 X Burial 2 Cremation	3 Removal fr	om State crema	atory or othe	on (Name of ceme r place) alr	fax	Date	20c. Location -	City or Town, State		
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Baltimore, MD 2' permit. Pages I and 2 should Department of Health and Mo Important: If item 27 is ms injury or other traumatic er		1. Signature of Puneral Service Licensee 22. Name and Address of Facility 1 alriax Memorial Fig.										
	_	23a. Part I. Enter the disease, or	complications that a	ounced the death. Do a								
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Examiner		Immediate Cause (Final disease or condition resulting in death)		unt Force Injuries	3					Death		
		Sequentially list conditions,	b									
	ner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence of):								
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Vita	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 l	npatient 2 ER/O	outpatient 3				Residence 6	Other: Scene		
n of ding Ph		27. Manner of Death	28a. Date	of Injury 28b.	Time of Inju		at Work?	28d. Describe	how injury occurred			
ion feath.	흹	1 Natural 5 Pendi 2 Accident Inves	ng Dec 26,	2010 010	0 hrs	1 Yes	2 🗸 No	'assenger	SUV rollover			
ViSi or At fier d Direct in by				of Injury - At home, fa	arm, street,	factory, office build	ding, etc.			or Rural Route Number, City		
Division pital or Attent ours after death teral Director: filled in by the	Certification:	4 Homicide	mined (Specify)	Major Road / H	ighway		s	or Town, S Southbound F	Route# 295 Norti	n of Route# 19, Laurel, Md.		
				t of my knowledge, de								
To the How within 24 h To the Fur	Medical		and manner st	f examination and/or i ated.	nvestigation			the time, date				
	≥	29b. Signature and title of certifier				29c. License n				(Month, Day, Year)		
		pul -		NP		O.C.M.I	E.		December 2	6, 2010		
_ 10		30. Name and address of person		` ′	444.5	onn Cárà D	-14:	24204				
,		Russell Alexander MD.		edical Examiner		enn Street, Ba	aitimore, ML	21201				
St: Regist		31. Date filed (Month, Day, Year) NFC 2 8 2010	Mary SZ. KO	gistra s Signadire								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12/25 PAUL MICHEAL RIVERS $_{\mathtt{A}}^{\mathsf{M}}$ Medical 12:03 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FUTURE CARE NURSING HOME CLINTON PRINCE GEORGE'S 6. Sex 1 **X** M 2 □ F Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min **Director** 302-46-9592 59 leveland OHIO Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location notified at Director 10d. Inside City Limits 28a-f 1 X Yes 2 No Maryland Prince George's Upper Marlboro 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a o event, the Medical Examiner must be Funeral 8612 Monmouth Drive 20772 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ğ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) l Hygiene. other than "ı Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Auto Salesman</u> Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Paul Rivers Delores Terrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie Rivers / Wife 8612 Monmouth Drive Upper Marlboro, Maryalnd 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify Resurrection 12/30/2010 _Clinton, Maryland 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike forestville, Maryland 20747 First . Sitter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, / r heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown g Unknown P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed' 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 X No Other: 1 🗌 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury Division s after death.

I Director: Aff
d in by the fu 1 🗌 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 0069711 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fort Washington, MD TINKUMAR DUSHI 11701 Livingrton Road Suite 101 31. Date filed (Month, Day, Year) 32. Registrar

DHMH 17 Rev 7/2009

Registrar

of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 21 Chery1 Lou S1acum 2010 10:20a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 911 Race Street Cambridge Dorchester 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Months Hours April 10, 214-42-8776 Director 65 1945 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Dorchester Cambridge death with the Man 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 911 Race Street 21613 USA 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes If Yes, Give 2 X No within 72 hours after 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 Divorced Completed Year or Dates d other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) census worker census bureau Be filed permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles G. Slacum Louise Tyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tamara Bozman daughter P. O. Box 637, Great Mills, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State Crematory of Delmarva 4 ☐ Donation 5 ☐ Other (Specify) 12/27/10 Delmar, DE Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St. Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Opset and Death Physician/ probable athlerosclerotic cardiovascular disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner hypertension 10 years Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or, Hospital or Attending Physician: The law requires that the death certificate be executed vate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ hyperlipidemia Completed 1 Yes 2 No 3 X Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 ♣ No After this certificate 1 ☐ Yes 2 ☐ No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes Other: 4 \square Nursing Home 5 $\overline{\mathbf{X}}$ Residence 6 \square Other (Specify) 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DCA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? Accident Investigation within 24 hours after deat

To the Funeral Director:
completed filled in by the 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 3 🗌 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H059973 12/23/10

State

Registrar

100 Bramble St., Cambridge, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.O.

Registrar's Signature

Patricia Johnson

DEC 27 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ANNA TAFFORD Physician/ Month 16.31p.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Randallstown Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 2, 1922 6. Sex **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🛣 F Days 214-14-5696 88 Maryland Yrs. Director Jsual Residence of Decedent 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Carroll Eldersburg 1 Yes 2 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1629 Brimfield Circle USA 21784 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Completed 3 X Widowed 4 Divorced Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) administrative director hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Calvin Louis McGuire Blanche Ellen Pearson Department of Health and Important: If item 27 is n any injury or other traum. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Margaret C. Bongiovani daughter 1629 Brimfield Circle, Eldersburg, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crematory of Delmarva: 12/20/10 Delmar. DE 22. Name and Address of Facility Thomas Funeral Home P.A. re of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ CARDIOVASCUAR DISEASE ATHERUSCLEROTIC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? TRACT INDICTION, ATELECTISIS OF 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DNJnknown 24b. Were autopsy findings available prior to completion of cause of death? GIRS PRUCTIVE 24a. Was an autopsy performed' 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 054288 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

RAMASWANY I

DEC 2 1 2010

31. Date filed (Month, Day, Year)

RANGARAIN

Registrar's Signature

NORTHWEST HOSPITHL CONTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Thomas Edward Stavish December 2010 7:05 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 25538 Joy Lane Montgomery Damascus Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 25, 9. Birthplace (State or Foreign Country)
D • C • 6. Sex Funeral 7. Age (In yrs. last birthday) Months 1 X M 2 - F Days Min. **Director** 215-48-6544 53 Sept. Usual Residence of Decedent show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25538 Joy Lane 20872 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black. White, etc. 1 Never Married 2 😾 Married þ 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Project Manager Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental I sem 27 is marked o ပ should be Theodore J. Stavish Mary Margaret Wade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim L. Stavish/Wife 25538 Joy Lane, Damascus, MD 20872 Page 1 and 2 tem 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite Date 1 KBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Dec. 2010 injury or Gate of Heaven Cemetery 4 Donation 5 Other (Specify) Silver Spring, 21. Signature of Funeral Service License 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Rectal Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transit that the death certificate be executed Cause (Disease of finjurathat initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Live Birth 2 Li retail doc.
Pregnant at time of death signed by the atte Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires Completed 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🕱 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 A Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending injury work?
1 Yes 2 No

Box 68760 P.O. Records, Hospital or Attending Physician; Division of Vital pleted filled in by the funeral director, s after death.

de 6 Could not be cide determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)		g (Street and Number or Rural Route Number, lown, State)							
1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)							

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Piccard Dr. Pockville, MD 20850 1396 MD Hwano -60 n

State Registrar

Medical

29a. Certifier (Check only one 29b. Signatur

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death George Bernard Skinner December 19, Day 2010 Medical 44 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7620 Maple Avenue, Apt. 414 Takoma Park Montgomery **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign XX M 2 □ F **Director** Months 218-24-3435 July 6, 1929 Hours Country) Maryland Yrs. 81 Usual Residence of Decedent ms 23a or 28a-f show must be notified at filed within 72 hours after death with the Maryland 10a, State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Takoma Park 1 Yes 2 No 10e. Street and Number 10f. Zip Code Funeral 10g. Citizen of What Country? "natural", or items 23a 7620 Maple Avenue, Apt. 414 20912 USA 11. Marital Status traumatic event, the Medical Examiner 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Z No Korean ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 X Yes Black, White, etc. 1 ☐ Yes 2X No Completed 3 Widowed 4 Divorced If Yes, Give Specify: Specify: White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Bricklayer Be Construction 17. Father's Name (First, Middle, Last) 'age 1 and 2 should be fill ent of Health and Mental nt: If item 27 is marked or y or other traumatic evo 18. Mother's Name (First, Middle, Maiden Surname) ည George Bernard Skinner Mary A. King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Diane Shimulunas/Stepdaughter 5934 Woodbine Road, #46, Woodbine, MD 21797 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1
Department of
Important: If it
any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Date 20c. Location - City or Town, State Metropolitan Crematory Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 Michael K. Hales 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Physician/ Set and Death Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is litered enter.) Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): bunal Physician/Medical Box 68760 nding t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery 1 Yes 2 9 Unknown Pregnant at time of death Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of perform death? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မှ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) Director: After 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af Accident Suicide Investigation 1 Tes 2 No 6 Could not be in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \square Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Gignature and title of certifier

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

5+1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Carroll Chester 19 Year 2010 Skinner DECEMBER. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Prince George's Lanahm Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Jan 28 **Funeral** 9. Birthplace (State or Foreign Days Hours Min. 229-32-8752 Months 78 Year 1932 Virginia Director Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Prince George's Greenbelt 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 22 Ridge Road, #222 20770 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, was Decedent Ever in U.S. Armed Forces? 1X Yes 2 No If Yes, Give Year or Dates 1952-1954 Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify White 3X Widowed 4 □ Divorced Specify Completed Stunner, Carurth Baltimore, Maryland 21215-00 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frederick Skinner Rubv Trumble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Sprouse -stepson 82 Branch Lane Gordonsville, Virginia 22942 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State MD4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 1/5/2011 Cheltenham, Maryland 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Monded 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph sician/ Onset and Death Cardiorespiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Coronary Artery Disease if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): death certificate be executed e attending physician and of or use as the burial-transit Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be exe Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 2 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 Pres 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No After this certificate I 2 No 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Hospital Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending injury Accident Suicide Investigation 1 Yes 2 No Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined hours after within 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Certifying Nurse Praction 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D65346 December 20, 2010 ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add

Registrar
DHMH 17 Rev 7/2009

State

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31. Date filed (Month, Day,

7235 B

Hanover Parkway Greenbelt, Md. 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 21, 2010 10:05 A M Lillian SHAMES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1801 E. Jefferson Street #622 Montgomery Rockville If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 1 ☐ M 2 ☐ XF 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Sept. 23, 1913 New York Director 066-03-7086 Usual Residence of Decedent or 28a-f shov 10c. City, Town or Location th and Mental Hygiene.
It is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Directo Rockville Maryland Montgomery 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 1801 E. Jefferson Street #622 20852 Funeral United States . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 21215-0036 Specify: White 1 ☐ Yes 2 💢 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Bookkeeping Bookkeeper Baltimore, Maryland 2 permit. Page 1 and 2 should be filed will be artment of Heath and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ida Schwartz Sam Hartstein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9102 Fall River Lane, Potomac, MD Daniel Shames, Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 V Burial 2 Cremation 3 Removal from State 4 Donation 5 Pother (Specify) Judean Memorial Gardens 12/23/10 Olney, MD 21. Signature of Juneral Service Licensee Torchinsky Hebrew Funeral Home Carroll St., NW. Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive disease or condition resulting in death) Medical Due to (or a a consequence of) Examiner oronany Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Fibrillatio Due to (or as a consequence of): resulting in death) Last burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Hypettension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Breast 24a. Was an autopsy performed Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 D Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 Inpatient 2 Inpatient 3 Inpatient 2 DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending М Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Critifying Nurses Practic near 15 the cent of my knowledge, death occurred at the time, date and place, and the cause(s) and manner stated. Swithin 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) P MD D69568 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , Rockville, MD 20852 E Jefferson St A chilaka marri 1801 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

DEC

Box 68760

P.O.

Division of Vital

1 - For Amend Item 25 State of Maryland / Department of Health and Mental Hygiene Of Health And Mental 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month November Physician/ Wilmouth T.N. Scotland 2010 10:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 7, 1929 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 M 2 □ F Days Hours Min. Country) Antigua Director 580-02-7628 Yrs. 81 Usual Residence of Decedent 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director USVI 1 Yes 2 X No St. Croix ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral filed within 72 hours after death with #162 Williams Delight 00841 USA items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. , or þ 1 Never Married 2 X Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Specify Black "natural" 3 Widowed 4 Divorced Completed Year or Dates. Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Pastor Religion Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ pe Leonard Scotland Olive Roberts permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #162 Williams Delight, St. Croix, VI 00841 Helenita Scotland (Daughter) 20c. Location - City or Town, State Croix 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Kingshill Cemetery Dec.4,2010 Christiansted,USVI 21. Signature of uneral Service Licenses 22. Name and Address of Facility
James Memorial Funeral Home
6AA La Grande Princess, St. Croix, USVI 00820 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Approximate Interval Between shock, or heart failu Immediate Cause (Final disease or condition resulting in death) k, or heart failure. List only one cause on each Physician Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner CERTIFICATION APPLICED BY MEDICAL EXAMINER the Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical Records, P.O. Box 68760 as the IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No for Month Day Year 1 Yes 2 Unknown page 2 should be detached the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? Be Completed by LENOTTE CARDIOVASCUTAR 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician:
Within 24 hours after death.

To the Funeral Director. After this certifical completed filled in by the funeral director, I **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 \square No Other: Certificate: To 1 ► Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) LINE 1201 State Registrar

. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are, Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Edith Ann Smack 9:00 PM Medical -Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death oastal at the Hospice icomico lisbury 5. Social Security Numbe 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Days 1 🗆 M 2 🕱 F April 8, 1938 Months Hours Min. 215-36-1641 New Jersey Director 72 Yrs Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at Director 10d. Inside City Limits or 28a-f Pittsville 1 Yes 2 X No Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 34104 Old Ocean City Road 21850 USA 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 0 Completed by 1 ☐ Yes 2 🏋 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: and Mental Hygiene.
is marked other than "natural", 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Homemaker Own Home Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important; If item 27 is marked any injury or other traumatic ev ည Charles Emerson Taylor, Sr. Anna Carolyn Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Edward Taylor/Nephew 34094 Old Ocean City Road, Pittsville, MD 21850 EQIH Baltimore, 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Speats) Crematory Of Delmarva 12/25/2010 Delmar, Delaware 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 3171 [212 Old Ocean City Road, Salisbury MD 21802 a. Part 1. Enter the disease, or or mplicatio is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one consequences are sent and the sent failure. Interval Between Onset and Death nysician/ Immediate Cause (Final DMY disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Lineary in Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year signed by the at d be detached fo Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| Completed 1 Yes 2 No 3 Probably 4 Unknown should 24a. Was an 24b. Were autopsy findings available page 2 s autopsy prior to completion of death? performed 2 No Yes 2 NO 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 \(\text{Yes} မ 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending hours after death. ineral Director: Af 1 Yes 2 No the 1 Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check within 2, To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 2010 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner NWYSING HEME. Worcester MO 9 Birthplace (State or Foreign last birthday) **Funeral** 1 ☐ M 2 X F Hours Min Director Usual Residence of Decedent 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Evaninar must be notified at 1 ☐ Yes 2 XNo Director 10g. Citizen of What Country? 10e Street and Numb Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 □ Yes 2 X No Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. int: If Item 27 is marked other than College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be (Injury or other traumatic . Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Department of Health a Important: If Item 27 is any Injury or other trau <u>once.</u> pouse Date 20c. Location - City or Town, State 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other) 21. Signatura of Funeral Service Licensee Temperance Ville VAds am 23a. P. 11. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or it spiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed and burial-trar Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ned by the a 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2, ANO 2 1 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica filled in by the funeral director, Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 🖸 No 1 ☐ Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ### Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title or certifier 29d. Date signed (Month, Day, Year) 29c. License number 2010 27 Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Division or Vital Records, the Funeral Director filled in by

> State Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

randis

and manner stated.

,VAMC 50 IRVING STREET NW, WASHINGTON, DC 20422/688 SONIKA PANDEY, M.D.

31. Date filed (Month, Day, Year, DEC 2 7 2010 29c. License number

MD# D0058627

29d. Date signed (Month, Day, Year)

DECEMBER 20, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Shakeia 9:04PM 2010 Decembe Sneed Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltimore if Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Yea
March 17, 6. Sex 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 □ M 2 🖾 F Director 218-92-8952 31 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 No Landover Prince George's Maryland 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be ronce. Funeral 20785 United States 7901 Scott Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 X Never Married 2 Married African American Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private 10th Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Beverly Sneed John Mapp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20608 22801 Christ Church Road Aquasco, Md. Thuriel Gilmore Sr. - Uncle 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State January 7, 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Washington, DC Glenwood 2011 21. S. nature of Funera Service Lic-22. Name and Address of Facility Stewart Funeral Home, Inc. 20019 4001 Benning Road NE Washington, DC 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, otherst failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multi-organ failure Physician Medical resulting in death) Due to (or as a consequence of): Examiner Hemorrhagic shock week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Throm bocy topenia, Due to (or as a consequence of): unknown etiology week Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi and attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) signed by the and be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? و کا disease, Lupus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury work?
1 Yes 2 No 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu s after death. Accident
Suicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗔 only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 12/27 2010 Resident Physician 1205095106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. President St. Unit 1504, Baltimore, MD, 21202 675 Milan Vora 31. Date filed (Month, Day, Yea 32. Registra/s Signature State JAN 0 3 2011 Registrar

ype or Print in Black Indelible Ink. Ensure All Copies Are Legible.	10001
State of Maryland / Department of Health and Mental Hygiene 0	1:2621

			For State	State o	f Marylar	•	artment (rtificate			ınd Me		jienė leg. No.	UIU	1,2021	
			Registrar Decedent's Name (First, Middle, Last)						2	2. Date of Dea	ith		3. Time of Death	_	
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A STATE OF	/Medic Examin		Aa. Facility Name (If not institution, give street and number) 4b. City, Town, or Locatio								12/20/		County of Deatl		
1	= Zuiiiii		HARFORD GARDEN		BALTI	MOR	E			HA	RFORD				
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Months [Year Days	If Under 2 Hours	24 Hrs. 8 Min.	B. Date of Birth (Month, Day	, Year)	Coi	place (State or Foreign Intry)	n
W	Director		578-50-6847	1 🔀 M 2 🗆 F	72_	Yrs.					11/21/	1938	Wash	ington, DC	,
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	the 28a-	Director	Maryland Frede	TICK	I I	ederic	10f. Zip C	ode				10g. Citiz	en of What Co	untry?	
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	ms 2	Funeral	11. Marital Status		edent Ever in U	J.S. 13.			spanic Orig	gin? (Spec	cify Yes or No- lican, etc.)		4. Race - Amer Black, White		_
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21215-0036	n 72 hours after death with the Marylan "natural", or items 23a or 28a-f show adical Examiner must be notified at	Completed	15. Deceden (Specify only highe	t's Education at grade completed)		16a. Dece (Give	dent's Usual (kind of work DO NOT use	done du	tion u <i>ring m</i> ost	t of working	g	16b. Kin	nd of Business/	ndustry	
121	within	m d	Elementary/Secondary (0-12)	College (1-4or 5+)		c Work					Prix	vate		
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ther the Medical Examiner must be notified at		17. Father's Name (First, Middle,	Last)		1 4511	C WOLL				(First, Middle,				_
an	d be ental ked o	To Be	James Edward S	kinner					Mar	v Em	ma Wrig	2ht			
Maryland	shoul nd Minari	-	19a. Informant's Name/Relations			19b. Maili	ng Address (S	Street a		-			Town, State, Z	ip Code)	
	alth a 27 is 27 is r trai		Anthony Skinne	r / Nephe	W	2019	Sumner	Dr	ive E	rede	rick, N	Maryl	land 21	702	
altimore,	iges 1 and 2 should be filed within 72 hc nt of Health and Mental Hyglene. : If Item 27 is marked other than "nature or other traumatic event, the Medical		20a. Method of Disposition	о Пр		Place of Dispo cemetery, cre	osition (Name matory or oth	of er place	9)	Da	ate	20c. Loc	cation - City or	Town, State	
Ĕ	Pages nent of P ant: If Ite ury or o		1⊠ Bunal 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			rt Lin	coln			12/3	1/2010	Bre	entwood	, Maryland	
alt	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau		21. Signature of Funeral Service	Licensee									Homes,		
8	97 = 29		Tut at	W 11	40108							_	e, Mary	Land 20747	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the dea each line.	ith. Do not en	ter the mode	of dying	g, such as	cardiac or	r respiratory ar	rest,		Approximate Interval Between Onset and Death	
4	Physician		Immediate Cause (Final disease or condition resulting in death)	a			emer	M	a						
	/Medical Examiner		resulting in death)	Due to	(or as a conse	quence of):									
ш	19.	<u></u>	Sequentially list conditions,	b. — Due to	(or as a conse	quence of):									_
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<	`										
Ć,	cate be executed oblysician and the burial-transit	Exal	resulting in death) Last	cDue to	(or as a conse	quence of):									_
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Box	leath certific attending p I for use as	N/UE	IF FEMALE: 23b. Was decedent pregnant		itcome pf pregr birth 2 ☐ Fet		⊒Ectopic pre	gnancy				2	23d. Date of de	ivery Day Year	
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on	Attending r death. ector: After by the funer	tion	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	19	nth, Day Year)	Injury	M		<br Yes 2 □	No					
Division or	I or Attend after death. Director: /	ifica	3 Suicide 6 Could 4 Homicide determ	.: I Zoe, Plac	e of injury - At I	home, farm, st	reet, factory,	office		2	28f. Location (3	Street an	nd Number or R	ural Route Number,	
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	7 wit	-	29b. Signature and title of certifie	1 dux	2 (MD				593	14				
•			30. Name and address of person	who completed	ing of death (It-	m 22a) /T	Print\	3-		^	0		1-7	[10	_
1	_2		MI + + W	who completed cal	se di death Me	Wal	tham	W	000	Rd	- 16WE	1716	e Mr	21234	
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Date filed (Month, Day, Year)

32. Registar's Signature

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Η. Towers 23, 5:10 a M Jack Dec Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Montgomery Hospice-Casey House If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours Min. (Month, Day, Year Country) 1 🗶 M 2 🗆 F SD 577-54-0675 96 Director Nov. Usual Residence of Decedent ms 23a or 28a-f show must be notified at Departies. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery Ashton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20861 USA 1200 Tucker Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2X Married 1 X Yes 2 □ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Completed Year or Dates. 1942-46 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture 5+ Radio Broadcaster Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Gertrude Tripp Charles Towers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1409 Tucker Lane, Ashton, MD 20861 Jeanie Kemp/Daughter Baltimore, Date 29 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Dec. Norbeck Memorial Park 2010 Olney, Maryland 4 Donation 5 Other (Specify) Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Paralysis Agitans Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death
Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No Yes 2 X N 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Other: 1 ☐ Yes 2 🙀 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural injury 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 **Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signaty re and 29c. License number 29d. Date signed (Month, Day, Year) R143201 December 23, 2010

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month,

UEC

30. Name and address of person who completed cause of death (Item 23a) (Type. Print)
Debrah Miller, CRNP 1355 Piccard Drive, Rockville, MD 20850

. Registrar's Sign

10-09733

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Robin Elaine T	urne	State of Maryland / Department of Health and Menta 1- For State Registrar Certificate of Death	al Hygiene	2010 Reg. No.	:2523
Physic Medical Exam		1. Decedent's Name (First, Middle,Last)	2. Date of De	eath	3. Time of Death
Medical Exam	III	ROBIN ELAINE TURNER 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of light and	Decemb	er 17, 2010	1145 hrs
		6902 Assett Drive Hyattsville	Death	4c. County of Dear Prince Georg	
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2.		Birth(MM/DD/YYYY) 9. Bi	rthplace (State or
Directo	1	578-90-4176 1 M 2 F 50 Yrs. Months Days Hours	Min. SEPT.	Porei	gWASHINGTON
, a	7	Usual Residence of Decedent 10a. State 10b. County 10c. City Town or Location			DC
i ow any		166. Oily, 16 mil of Escation			10d. Inside City Limits
Maryland • 28n-f show d at once.	cto	MD PRINCE GEORGE'S LANDOVER 10e. Street and Number			1 X Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens Importment of Health and Mental Hygiens Important: If item 27 is marked other than "matural", or items 33a or 28a-f sho njury or other traumatic event, the Medical Examiner must be notified at once.	Director	10f. Zip Code 6902 ASSET DRIVE		10g. Citizen of What Cou	ntry?
with the 18 23 and 18 and 18 23 and	<u> </u> <u> </u> <u> </u> <u> </u>			USA	DI DI
leath ' r item	Funeral	1 Never Married 2 Married Armed Forces? 1. Vas Decedent of Hispanic Origin: If Yes, specify Cuban, Mexican, Po	? (Specity Yes of Nuerto Rican, etc.)	Io- 14. Race - Amer White, etc.	ican Indian, Black,
after (by F	3 Wildowed 4 A Divorced if Yes 2 X No specify:		Specify: BL	A C.K
hours natur	pa	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind	d of work done	16b. Kind of Business/	
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l withing giene.	E	17. Father's Name (First, Middle, Last) 4+ CHIEF BUDGET ANALYS		GOVERNMENT	<u> </u>
215. e filed al Hy ced of	Be C	DEDNADD WIDNED	lame (First, Middle,	,	
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 27 is marked other than umatic event, the Medica	To E	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number			Zin Cada)
MD 12 sho th and 1.27 is		PORTIA L. PEAY-STEPTOE/DGT. 839 FLORIDA AVENUE			
Baltimore, MD 21215-C permit. Pages I and 2 should be filed to Department of Health and Mental Hygi Important: If item 27 is marked oth injury or other traumatic event, the I		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery	Date	20c. Location - City or	
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Baltimore, permit. Pages I an Department of Hea Important: If ites		21. Signal to of Funeral Service Licensee 22. Name and Address of Facility			
E S E	J	7474 LANDOVER F	ROAD HYAT	TSVILLE, MARY	
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardifailure. List only one cause on each line.	ac or respiratory an	rest, shock, or heart	Approximate Interval Between Onset and
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d d ansit		events resulting in death) Last Due to (or as a consequence of): d.			
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'60, ate be	좕	IF FEMALE: 23c. If yes, outcome of pregnancy			-
687 ertific ding p	an/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pre	gnancy	23d. Date of delivery Month Date	ay Year
Box 6876(death certificate the attending physical for use as the b	Physician/Me	1 Yes 2 No 9 V Unknown			
3 € € €	퇀	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23o Did to	bacco use contribute to the	
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cian: The certificate ector, page		25. Was case referred to medical 26 Place of Death (Che	1 ✔ Yes	2 No 1 ✓ Yes	2 No
/ital	ω̈́	examiner? [Hospital:]			
i of Vital Records, ing Physician: The law require After this certificate has been si uneral director, page 2 should b	<u>2</u>	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		Residence 6 Other:	Scene
ath.	[류	1 X Natural 5 Pending (Month, Day, Year)	20d. Describe 1	low injury occurred	
Division fal or Attendi rs after death. al Director: /	<u>[</u> 2	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f Location (S	treet and Number or Rura	Route Number City
Dital of surs at Dital Dital	ŦΙ	4 Homicide determined (Specify)	or Town, St		rodic Number, City
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director A completely filled in by the fu		29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the cause	e(s) and manner as stated	
Fo the vithin Fo the comple	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d at the time, date a	and place, and due to the	cause(s)
	Ž 2	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month	n, Day, Year)
		Theolow W. Bus There and O.C.M.E. U.	₩E	December 18, 201	0
D	3	30. Name and address of person who completed cause of death (Item 23a)		-	
1-		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimo	ore, MD 21201		

State 31. Date filed (Month, Day, Year)
Registrar JAN 0 4 2011

32. Registrar's Signature

Please Type or Print in Black Indutible Ind. Hostifel All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vance Mae Virginia December 2010 10:13 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Western MD Regional Medical Center Cumberland Allegany If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 ⋤ F Director 216-14-1674 89 2/03/1921 Maryland Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

tem 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified PΑ Bedford Artemas 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1385 Elbinsville Road 17211 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black White etc by 1 Never Married 2 Married 2 TyNo 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 Divorced White Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Secretary Laboratory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Fazenbaker Messie Mae Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki Lyn Nissley /Daughter 902 Second Avenue, Altoona, PAitem 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or otl 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Fairview Christian Cem. 12/24/2010 Inglesmith, PA 22. Name and Address of Facility Adams Family Funeral Home, P.A. Sign 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of APPROVED BY MEDICAL EXAMINER Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last CERTIFICATION Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 Yes 2 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1X Yes Hospital Other: 2 😾 No 욘 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural s after dec. al Director: Afte 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and the of ertifier 29c. License number 29d. Date signed (Month, Day, Year) D0025406 December 20, 2010 arm Will 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Lamm, M.D., 12501 Willowbrook Road, Cumberland, MD 21502 31. Date filed (Month, Day, Year)

JAN 13 2011 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Hazel Dukes Wheatley 17 2010 December 7:30 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cambridge Chesapeake Woods Center Dorchester Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Feb. 20, 1917 1 □ M 2 🗓 F Months 93 Mary land Director Yrs 167-16-5448 Usual Residence of Decedent or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland | Dorchester Cambridge 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 525 Glenburn Avenue USA 21613 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Baltimore, Maryland 21215-0036 þ 1 Never Married 2 Married ☐ Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Office Clerk Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Wesley Dukes Edith Frances Morfan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janis Werner/Daughter 6322 Snug Harbor Road, East New Market, MD 21631 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place) Crematory Of Delmarva 12/18/2010 4 ☐ Donation 5 ☐ Other (Specify Delmar, Delaware 21. Signature Fun ral Servi 106 Main Street Name and Address of Facility Zeller Funeral Home, 21630 Box 207 East New Market, MD, 21631 mart . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Zheimers Physician/ men 4CAC Medical resulting in death) Due to (or as a onsequence of): Examiner Sequentially list conditions, if any adding to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Directo for as a consequence of Exam the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year cate has been signed by the page 2 should be detached Unknown ☐ Unknow Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' After this certificate funeral director, pag 2 KNO 1 ☐ Yes 2 DN 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 XXNo Other: မှု 4 Mursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending wor 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation within 24 hours are deciting the Funeral Directors completed filled by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one 29b. Signature and title of certifier 29d. Date sig ned (Month, Day, Year)

State Registr<u>ar</u> a

30. Name and address of person

100

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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NAGR

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g911 1-25-11 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 102th 24 / 240 10 Year Physician/ Beatrice J Washington 9:50-а м Medical 4b. City, Town, or Location of Death Clinton 4a. Facility Name (if not institution, give street and number) Prince George ʻ≲xaminer Bradford Oaks Rehab Center 7. Age (In yrs, last birthday) 92 vrs 5. Social Security NG 67 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country Va 1 - M 2/-Months Days Hours Min. 06/-7/ 230-12-31 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho Director Temple Hills Prince George 1 🗌 Yes 2 🔀 No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20748 USA 2606 Afton st be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married SpecBlack Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXIII Specify: If Yes, Give Year or Dates 3√Widowed 4 □ Divorced Completed and Mental Hygiene.
is marked other than "natur 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Food Service Elementary/Seconday (0-12) College (1-4 or 5+) Dietician 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1
Department of Health and Menta.
Important: If item 27 is markedany injury or other traumatic ev. Isabelle Seaton ည Collier Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2606 Afton St Temple Hills Md 20748 Geraldine Moore(Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State /30 2010 cemetery, crematory or other place) 1 N Burial 2 Cremation 3 Removal from State Richmond Va Forest Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Licenses 22. Name and Address of FacilityScott Funeral Home 115 E Brookland Park Blvd Richmond 64 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ (4 KOS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy pital or Attending Physician: The law requires that the death ours after death.

eral Director: After this certificate has been signed by the atter filled in by the funeral director, page 2 should be detached for u in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2XXNo 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 **X**X10 မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XXNatural 5 Pending work 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital of the Hours a To the Hospital within 24 hours a To the Funeral Completed filled Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination areas in reasonable and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year DECEMBER 20 2010 **Physician** 9:24 A M WRIGHT KAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FT. WASHINGTON HOSPITAL PRINCE GEORGE'S FORT WASHINGTON 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) OCT • 20 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Days 1 □ M 2 🗗 F 1940 WASHINGTON, DC 577-54-6906 70 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It of Madical Examinations to profited at 1X Yes 2 □ No Director MD PRINCE GEORGE'S ACCOKEEK 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20607 USA 1812 MAPLE LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 📉 No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married **BLACK** 1 ☐ Yes 2 🛣 No Specify: à 3 Widowed 4 Divorced Be Completed 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE STOCK CLERK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LEE O. WILSON INEZ DEW ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health and Important: If item 27 is any Injury or other trau 1812 MAPLE LANE ACCOKEEK, MARYLAND 20607 SAMUEL WRIGHT JR./HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12/28/2010 BRENTWOOD, MARYLAND FT.LINCOLN CEMETERY 4 ☐ Ponation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final dio myopathi disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of): physician ā attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Ye a 4 ☐ Pregnant at time of death 5 ☐ Other (specify)

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

Medical Certification: To Be Completed by Physician/Medic
To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the
within 24 hours after death.
6

in the past 12 months? 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2▼No 24a. Was an autopsy performed? Yes 2X\(\text{\text{No}}\) 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifie 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier M.D

State Registrar

31. Date filed (Month, Day, Year)

MYSORE

MID 5100 AUTH 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WAY, SUITLAND

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 December 15:01 Valiant A. Washington, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 1513 November Circle # 303 Silver Spring 8. Date of Birth (Month, Day, Year) May 5, 1950 Birthplace (State or Foreign Country)
 DC **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 1 X M 2 □ F Days Hours Director 577-66-6879 60 May Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Id be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 X Yes 2 □ No Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20904 1513 November Circle # 303 Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 Widowed 4 Divorced Year or Dates permit, Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Brick Mason Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ unk. Evie Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20613 Chere Sanders - Sister 13402 Danielle Court Brandywine, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 A Cremation 3 Removal from State 1/10/2011 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory Clinton, Maryland 21. Signature of Funeral Service Vcens e 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Privsician/ LUNG met disease or condition Medical resulting in death) Examiner nman Securitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death Unknown 9 Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen HIV 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform After this certificate 2 N 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🔲 No Other: မှ 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No n 24 hours arter he Funeral Director: Af 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 12-29-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARYARET CHANG \$210 Col colonial Lane Silver Spring MD 20910

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

JAN n 3 2011

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

For State AMEND#23eperMD1/10/11; BWI, MCO
RegistraMEND#29dperMD, 1/4/11, BWI, MCO

Certificate of Death

Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last) December Physician/ Young Dueece Norma 2010 Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (if not institution, give street and number) Examiner Prince George's Laurel Regional aure Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth , Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours Min. Delcont 20 av. 1926 Indiana 1 M 2 TyF 84 217-84-6434 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The street is marked other than "natural", or items 23a or 28a-f showing or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 🗆 Yes 2 🗓 No Silver Spring Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20904 3156 Gracefield Road, OP315 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 1, Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes : Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after postarinent of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinant injury or other traumatic event. White 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) own home Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cecil Pearl Stewart ည Clyde Spencer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 6156 Nightstreet Hill Columbia, Maryland 21045 Nyna Werner -daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1

Burial 2

Cremation 3

Removal from State Metropolitan Crematory 12/23/2010 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Marvland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonid Physician/ Aspiration disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner piratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death signed by the ar 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Pressure Hydrocephalus 1 ☐ Yes 2 🛱 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 124 hours after death.

e Funeral Director: After this certificate has le autopsy performed? Yes 2 N 1 🗆 Yes 2 🗶 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 28c. Injury at work? Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural
2 Accider
3 Suicide 5 Pending 1 Yes 2 No Investigation Accident completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed 2 and 2 av 20 10 29b. Signature and title of certifier D70093 Laurel Regional Hospital 7300 Van Dusen Rd. Lau 30. Name and address of person cause of death (Item 23a) (Type, Print) MD 20707

State Registrar 31. Date filed (Month, Day, Year)

27

32 Registrar's Signature

Laurel,

Charles Joseph Young

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2 Date of Death

Physici dical Exami		Charles Joseph							Month Decem	Day ber 30, 2	Year 010	0749 hrs
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Funeral Director			Sex 7. A	Age (In yrs. Ia 54	st birthday) Yrs	If Under Months s.	Days	If Under 24 Hours	/lin	of Birth(MM/D 06/195	Fore	irthplace (State or ign outlingshington,
		Usual Residence of Decedent								•		D.C.
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72 hou	ompleted	Elementary/Secondary (0-12)	College (1-4 o	r 5+)	during m	nost of working	ng life. D	O NOT use	retired)			
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23s or 28s-f ab or other tray	٤	19a. Informant's Name/Relationship Theresa L. Youn							or Rural Route			
and 2 she ealth and 2 traumat		20a. Method of Disposition	g/wire	20b. P	lace of Dispos	sition (Name	of ceme	tery.	ce Fred		ocation - City of	
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Baltimore, permit. Pages lar Department of Hee Important: If ite injury or other tr		4 Denation 5 Other Special Signature of Funeral Service Lice	afy:		iscopa	Name and A	drace o	f Eacility				Maryland
Baltimore, MD 2 permit. Pages I and 2 should permit. Pages I and 2 should pepartment of Health and N Important: If item 27 is minjury or other traumantic.		Clarx 9	1 00 = 11+	MOC	0817, 30	1195 Т	hree	B:	rinsfie	ld-Ech	nols F.	H., P.A. 11, MD20622
Physician		23a. Fart I. Entwithe disease, or on	mplications that cause	ed the death.	Do not enter t	the mode of	dvina su	ich as cardia	c or respiratory	arrest, shoo	ck. or heart	Approximate Interval
/Medical		failure. List only one cause on Immediate Cause (Final disease	each line. Calc a. Right	cific (Corona: Dary A:	ry Ath rterv	eros	clero Cardi	sis Wit omegaly	h Anoi	malous	Between Onset and Death
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c 68760, certificate be e ending physicia use as the buria	Ž	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outo	ome of pregn		etal death	3 [Ectopic pre	nancy	- 1	. Date of delive Month	ory Day Year
th cert trendir r use a	icia	past 12 months?	4 Pregnant	at time of dea		ther (Specif)		J	5 ,			
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Division of Vital Records, P.O. Bc To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached for	Certification:	1 X Natural 5 Pending		njury v,Year)	28b. Time of	injury 200		at Work? s 2 No	280. Descr	ibe how inju	ry occurred	
Division To the Hospital or Attent within 24 hours after death To the Fuoeral Director: completely filled in by the	tifica	2 Accident Investig 3 Suicide 6 Could n determi	ot be 28e. Place of	Injury - At ho	me, farm, stre	et, factory, o	ffice buil	lding, etc.		on (Street an	nd Number or F	Rural Route Number, City
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		dula late	in lee		10	(D.C.M	E.		Dece	ember 31, 2	2010
		30. Name and address of person wh	no completed cause o	f death (Item:								-
		Victor Weedn MD JD	Assistant Medic			V. Baltimo	re Str	eet, Baltir	nore, MD 2	1223		
S Regis	tate trar	31. Date filed (Month, Day, Year)	2011 32. Regist	rar's Signatur	1 1	Med						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12^{Month} Josephine Anderson 2010 A M 7:05Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Crofton Convalescent Center Crofton Anne Arundel If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign Months Days Hours Min. 286-16-2038 09/01/1920 Kentucky **Director** 90 Yrs. Usual Residence of Decedent Show 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 28a-f XX Yes 2 No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 3013 Belair Drive 20715 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2XX No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify: Specify: White Completed 3XXWidowed 4 □ Divorced and Mental Hygiene.
is marked other than "natur aumatic event, the Medical Is 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Health Care permit, Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Smith H. Tyler Bertha Maggard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Naugle/ Daughter <u>Everette Drive Bowie. Maryland 20716</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial XX Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore Washington [12/22/2010 | Laurel, Maryland 21. Signature of Cineral Cremath By Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Rd. Bowie, MD 20715 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a nonsequence of cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ Ao 3 ☐ Probably 4 ☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: ၀ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Norse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year, use of death (Item 23a) (Type, Print) 2 2 2010 State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Archambo Month Year VICGINIA 6: 00A M December 7010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Riva Terrace V Arnold Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min (Month, Day, Year) 18/1923 Pennsylvania **Director** 577-20-6748 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director Maryland Anne Arundel Riva 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3168 Riva Road 21140 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify: 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Goddard Space Flight Elementary/Seconday (0-12) College (1-4 or 5+) Center 12th Computer Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Shaver Ina Porter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen E. McLaughlin/ Daughter 3168 Riva Road, Riva, Maryland 21140 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Veterans Cemetery 12/22/10 Crownsville, MD 21. Signatur peral Pryice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between End-Stage Algheimers Dementia Immediate Cause (Final Onset and Death Physician/) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) signed by the attending physician and be detached for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Puneral Director: After this certificate has le Funeral director, page 2 s autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No ပ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at 1 Natural .vatural
Accident
Suici 5 \square Pending 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MSKNAPAMEM D D0057465 70/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \(S \) Rayapa FSR/M (1) \(283 \) S M (1) \(A \) \(28355min Ar- 5-703-Bultimore, MD. 71209 DEC 2 2 2010 31. Date filed (Month, 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

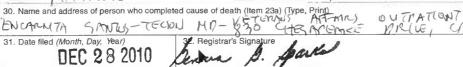
		٠	State Registrar	_	Cer	tificate of	Death	Reg	ı. No.	
	Physicia	an	Decedent's Name (First, Middle, Last) Edward	T. Atk	inson			2. Date of Death Month 23	Day 2010 Year	3. Time of Death 12:30 A M
1	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of Death	2001 20	4c. County of Death Talbot	12.00 11
	Funeral Director		5. Social Security Number 6. Sex 1212-22-5207	7. Age (In yrs. 83	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1)	(ear) 9. Birthp	place (State or Foreigr ntry) .C.
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Mary	s 1 and 2 should of Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty) James J. Atkinson		1	Ŧ .	and Number or Rural St. Michae		City or Town, State, Zip 21663	code)
more,	Pages 1 au nent of Hea int: If item iry or othe		20a. Method of Disposition 1 □ Burial ※ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State		sition (Name of natory or other place Cremato:	:		lisbury, M	
Бант	permit. Pages 1 Department of I Important: If ite any injury or ot once.		21. Signature of Funeral Service License	owski C.F.S.A			Ostrowski 18 St. Mic			
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of the NMRY	n. Do not ente	er the mode of dyi		respiratory arres		Approximate Interval Between Onset and Death
Invision of Vital Records, F.O. box 66/00, for the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	cate be executed physician and the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t						
	the death certifi y the attending ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	I death 3] Ectopic pregnand] Other (specify) _	су		23d. Date of deliv Month	very Day Year
cords, P	juires that n signed b		Part II. Other significant conditions cor	tributing to death but not res	ulting in the ur	4/-	ven in Part I.		acco use contribute to t	
HECOF e law requ has been e 2 shoul	ne law rec s has bee ge 2 shou	Completed by	CONGESTIVE HER	RT FAILU	PE			24a. Was an autopsy perform	ed? death?	opsy findings available ompletion of cause of
VIII	iclan; Th certificate ector, pag	Be Co	25. Was case referred to medical examiner?	lospital:		O+1	26. Place of Death	1 □Yes 2 (Check onl ne	Mino 1 ∐Yes	
5	g Phys er this eral dir	1: To	27. Manuar of Death	1 Inpatient 2 I	28b. Time of	28c. Inju	ry at 2	ne 5 Resider 8d. Describe hov	ice 6 Other (Special of the control	ify)
or Attending Phy or Attending Phy ther death. Director: After this in by the funeral c		Certification: To	1 ✓ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 1 ☐ Pending investigation 6 ☐ Could not be determined	(Month, Day, Year) 28e. Place of Injury - At he building, etc. (Specifical Control of the Contr	Injury ome, farm, stre]Yes 2□No	8f. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,
	e Hospita 124 hours e Funeral letely filled	edical C		sician: To the best of my knoner: On the basis of examination and manner stated.						
	ro th within ro th	Me	29b. Signature and title of certifier			29c. Licen	se number	29	d. Date signed (Month,	, Day, Year)

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State Registrar ENCARMAN SANUSTECION

31. Date filed (Month, Day, Year)

DEC 28 2010



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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UT U Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:42 AM MARIE H. ANDERSON Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SOMERSET SOMERSET GARDENS ASSISTED LIVING PRINCESS ANNE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 6/2/1916 1 🗆 M 2 🗶 F 94 MARYLAND Director 215-16-0803 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits lid be filed within 72 hours after death with the Maryland Mental Hygiene. Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No MD SOMERSET PRINCESS ANNE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12360 PALMETTO CHURCH ROAD 21853 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc. , or 1 Yes 2 X No If Yes, Give Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: "natural", 3 Widowed 4 Divorced Year or Dates marked other than "natu matic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) FEDERAL GOVERNMENT Elementary/Seconday (0-12) College (1-4 or 5+) TEACHER U.S. MILITARY 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. JOHN ANDERSON AGNES SKINNER should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 680 SPENCE DRIVE, SALISBURY, NC 28144 JOHN M. ANDERSON, NEPHEW 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) WOODLAWN MEMORIAL 12/29/2010 EASTON, MARYLAND . Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. J042 R MERCER 200 SOUTH HARRISON STREET, EASTON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MENTI Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director. After this certificate has been signed by the attending physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No ģ Month Day Year 4 Pregnant Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Division of Vital funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: 2 🗆 🕅 မ 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 MOther (Specify) ASSIST LIVING 27. Manne f Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Matural 5 Pending injury Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 23 **Physician** 2010 Owen 12:50P M /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 01ney Montgomery 17721 Lochness Circle If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
June 29 1960 Washington, D.C. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1**万**M 2□ F 224-62-6685 50 Yrs. Director Usual Residence of Decedent the Maryland 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Exame as must be redified at Md. 01ney 1 Yes 2 No Director Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20832 17721 Lochness Circle United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 X Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ğ 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) s 1 and 2 should be filed within if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Chester Alofs Joann Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heidi A. Mullen / Sister 25 Crescent St., Rochelle Park, NJ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/25/10 Alexandria, Va. * 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funetal Servic Lice P. O. Box 5038, Laytonsville, Md. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediae Cause (Final Physician Atherosclerotic Cardiovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760 attending physician lan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Physici 4☐Pregnant at time of death 5 Other (specify) P.O. | Yes 2 No ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by Chronic renal failure 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☑ No 2 No Division of Vital 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Cther: 4 Nursing Home 5 ■ Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🗹 No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: Injury 1 🗷 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide 24 hours a e Funeral i 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D39793 December 23, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20832 Christopher J. Mays, M.D. 18111 Prince Philip Drive, Olney, Md. 32. Registrar's Signature 31. Date filed (Month, Day, Year) Leneur

DHMH 17 Rev 1/200

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per 1h g912 2-11-11 vt State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Voor 5:10 P.M **Physician** December 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 9. Birthplace (State or Foreign 579-48-1916 218-48-7124 6. Sex 7. Age (In vrs. last birthday) **Funeral** y, Year Days 1 **X**M 2 □ F 29, JAN. 1933 DELAWARE 77 **Director** Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County show 1 ☐ Yes 27 No Director 28a-f MARYLAND QUEEN ANNE'S CHESTER 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ö UNITED STATES 1518 SAINT MARYS ROAD 21619 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No 1 ☐ Yes 2 **X**No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify ò Specify: WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) HEATING AND Elementary/Secondary (0-12) College (1-4 or 5+) 12 BUSINESS OWNER AIR CONDITIONING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental h ပ္ FREDERICK T. BARSTOW MARY E. CRANE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 GLORIA BARSTOW/WIFE 1518 SAINT MARYS ROAD, CHESTER, MARYLAND, 21619 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State DEC. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department of Important: If it any injury or o oonce. ō STEVENSVILLE, MARYLAND CEMETERY 2010 21. Signature of Funeral Service License FELLOWS, Add HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND, Approximate Interval Between Onset and Death ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1. Enter the disease, or complication shock, or heart failure. List only one ca se on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 - Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 I Unknown P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ of Vital Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed Pancreatic neuroendocrine tumor 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Tes 2 🗌 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 TInpatient Other: 4 \sum Nursing Home 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) ဂ္ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) l in by 4 - Homicide filled 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 2 To the I

Terun Mario 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

29c. License number RES-000 29d. Date signed (Month, Day, Year)

December 27, 2010

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Barcase December 1 Gregory 16 2010° 3:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 204 Roosevelt Westernport Allegany If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 216-22-7066 1 XM 2 - F March 3 1928 Maryland Director 82 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Allegany MD Westernport 1XXYes 2 □ No 10e. Street and Number 204 RC 10f. Zip Code 10g. Citizen of What Country? Roosevelt St Funeral 21562 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Ves 2 No WW 2

If Yes, Give Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after e filed within 72 hours after tal Hygiene. ed other than "natural", o white 1 ☐ Yes 2 No Specify. 3 Wildowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Paper Manufacturer Maintenance Supervisor 12 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gregory Barcase Lucille Patrone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
22612 Horserock Road, Westernport, Maryland 21562 19a. Informant's Name/Relationship (Type, Print) Jeffrey Barcase/ son 20a. Method of Disposition 20b. Place of Disposition (Name of 12/20/2010 Westernport Maryland 20c. Location - City or Town, State Philos Cemetery 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Boal Funeral Home The one 111 Church St, Westernport, Maryland 21562 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one caus Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) and I-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician a Physician/Medical Box 68760 IF FFMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performe death? certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one director 1 Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗡 Residence 6 ☐ Other (Specify) othe Hospital or Attending Physithin 24 hours after death.
The Funeral Director: After this ompleted filled in by the funeral directorial of the funeral directorial directori this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signati 29d. Date signed (Month, Day, Year) na 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Robert Bess JR, 122 Ashfield St, Piedmont, WV 26750 31. Date filed (Month, Day, Year) **DEC 2 0** Registrar's Signature 32 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legi

State of Maryland / Department of Health and Mental Hygiene

2. Date of Death

B<u>a</u>

24b. W

28f. Location (Street and Number

29d. Date signed

DEC

City or Town, State)

Baltimore

Certificate of Death

ble. 0 42638								
Year 0954 M of Death								
9. Birthplace (State or Foreign Country) 2010								
10d. Inside City Limits 1 ☐ Yes 2 ☑ No								
hat Country? States								
- American Indian, , White, etc. White								
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ate, Zip Code)								
City or Town, State MD 6633 Old Alexandria								
Approximate								
Interval Between Onset and Death								
of delivery th Day Year								
oute to the cause of death?								
ere autopsy findings available for to completion of cause of eath? □ Yes 2 □ No								
(Specify)								
or Rural Route Number,								
as stated. o the cause(s) and manner stated. ner as stated. Month, Day, Year)								
24 2010								

NB 10

Registrar

Medical

4 Homicide

29a. Certifier

(Check

29b. Signature and title of certifie

For State

Physician/

Medical

1. Decedent's Name (First, Middle, Last)

BUKER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

MD

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due

P19685

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Year Edward Steven Bogard 8:17 Medical December 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Western MD Regional Medical Center Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/19/1953 6. Sex Birthplace (State or Foreign Country) Funeral Days 1 X M 2 □ F 57 **Director** 493-60-7302 Missouri Usual Residence of Decedent 28a-f shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Allegany Frostburg 1 Tyes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 10139 Boston Street, USA 21532 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify. Completed 3 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Contractor Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward В. Bogard Dorothy Dawid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau Cecilia Bogard / Wife P.O. Box 42, Eckhart, MD 21528 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 12/28/2010 Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, 21. Signature of Funeral Service Licensee 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) rteriosclerotic Heart Disease Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause file of the cause (Disease or linjury Due to (or as a consequence of): Exami that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Dav Year g Unknown a Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician; The law requires Cerebrovascular Accident 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🎇 Unknown page 2 should Hypertension, Abdominal Aneurysm 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 X Yes 2 □ No Other: မ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury 24 hours after death. Funeral Director: A Acciden
Suicide 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D09157 December 27, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 124 W. Third Street, Cumberland, MD nas Paul Snow, M.D., 21502 31. Date filed (Month, Day, DEC 27 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2 19^{3y} 2010 4:40 \mathbf{P} M JOSEPH A. DOWLING Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death EASTON TALBOT WILLIAM HILL MANOR 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 1 XM 2 □ F 69 01/06/1941 **Director** 577-54-1011 DC Usual Residence of Decedent show 10h County 10a, State 10c. City, Town or Location within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Directo 1 Tes 2 X No ST. MICHAELS TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21663 9831 MARTINGHAM CIRCLE UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 Divorced 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) PRINTER LITHOGRAPHY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) THELMA LILLIAN KESTERSON EDWIN EARL DOWLING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh nt of Health a : If item 27 is 9831 MARTINGHAM CIRCLE, ST. MICHAELS, MD 21663 CAROLYN E. DOWLING / WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2X Cremation 3 Removal from State CHESAPEAKE CREMATION 12/21/2010 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA 200 SOUTH HARRISON ST., EASTON, MD 21601 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death INFARCTION MYOCARDIAL Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** DYSLIDIDEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 g Unknown 2 No 4 ☐ Pregnant : 9 ☐ Unknown the hed by s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by TENSION PARKINSONS Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings avallable prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 Hospital or Attending Physician: The 2 No 1 Yes 25. Was case referred to medical examiner? Division of Vital funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ဂ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu 725 8

i 24 hours after death. e Funeral Director: A

State

Registrar

Medical

1 Natural

Accident

4 Homicide

29a. Certifier

(Check

only one)

3 🗆

5 Pending

Investigation 6 Could not be

determined

EINBOLD MB 321 BLOOMINGDALE AJE FEDERALSBURG, M

son who completed cause of death (Item 23a) (Type, Print)

ATTENDING MD

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Bural Boute Number.

29d. Date signed (Month, Day, Year)

injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1- state-Amended #23a per MD, RG FCHD 12/29/10 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2 7 ay DEC. MARYETTA FRANCES BRADSHAW 2016 7:25A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 19656 WOOTTON AVE. POOLESVILLE MONTGOMERY Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/08/1960 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗹 F Hours Country) MD Director Yrs. <u> 217-78-7468</u> 50 Usual Residence of Deceden 10a. State within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🖫 Yes 2 🗌 No MD MONTGOMERY POOLESVILLE 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 19656 WOOTTON AVE. 20837 USA er than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 █ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 - Widowed 4 - Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) HOUSEWIFE DOMESTIC permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ LEO E. JENKINS RUTH VIRGINIA CROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAWN PORTOCARRERO/DAUGHTER 19656 WOOTTON AVE., POOLESVILLE, MD 20837 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12/24/201þ FREDERICK, MD 4 Donation 5 Other (Specify) STAUFFER CREMATORY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line., Approximate Interval Between O tand Death Immediate Cause (Final Physician/ udden Cardiac disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner <u>Left Ventricular Hypertrophy</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed as the burial-transi Cause (Disease or iinjury that initiated events High Blood Pressure attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ high blood pressure, diabetes mellitis type 2 Completed 1 Yes 2 No 3 Probably 4 Unknown Kecent Stroke (November 30, 2010) Obstructive sleep aprice 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 16 W autopsy Lung Mass probably cancer with Lymph node Metastases, Chronic Obstructive within 24 hours after death.

To the Funeral Director; After this certificate DISTES Yes 1 Yes 2 No 25. Was case referred to medic I Be 26. Place of Death (Check only one) examiner? မ 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 1495 Michae 4 Shad 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ ^{Day}₂9, 2010 7:00 December A M FREDERICK LEE BENTZ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 620 East Main Street Thurmont If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Nov. 9, 1935 Days Min. Hours Maryland Director 217-32-6475 75 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director 1 X Yes 2 No Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 620 East Main Street 21788 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 Black, White, etc 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White If Yes, Give Year or Dates. Peacetime 3 X Widowed 4 □ Divorced Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Print Operator Business Forms Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Brook Bentz Grace Virginia Wood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8206 Old Kiln Road, Thurmont, Maryland 21788 Scott Bentz Sr. / Son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Smithsburg Crematory | 12/30/2010 |Smithsburg, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen ROBERT E. DATLEY & SON FUNERAL HOMES, 615 EAST MAIN STREET, THURMONT, MD 21 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death CANCER Immediate Cause (Final ANCREATIC Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or, Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death this certificate has been signed by the ral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum_\) Nursing Home 5 \(\text{Residence}\) Residence 6 \(\sum_\) Other (Specify) 2 No Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA : After this funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending Investigation within 24 hours after death

To the Funeral Director: / Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0035152 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 S. Center 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12/30/2010 WALTER PLOWMAN BLOOM, SR. 11:20 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner DORCHESTER** 2918 PUNGY PATH CAMBRIDGE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X**] M 2 □ F Months Days Hours MARYLAND Director 62 218-50-1098 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No **CAMBRIDGE** MARYLAND DORCHESTER 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 2918 PUNGY PATH 21613 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify 3 Widowed 4X Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **MECHANIC AUTOMOTIVE** 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P HOWARD URBAN BLOOM HAZEL BURTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5311 BUCKTOWN RD., CAMBRIDGE, MD 21613 WALTER PLOWMAN BLOOM, JR. / SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
MID SHORE CREMATION CENTER BY 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 01/03/2011 CAMBRIDGE, MD 4 ☐ Donation 5 ☐ Other (Specify) COLLEEN CURRAN-BROMWELL, P.A 21. Signature of Funeral 22. Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each flipe. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): the attending physician and ned for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? After this certificate has page 2 autopsy performe 2 N 1 ☐ Yes 2 No Yes To the Hospital or Attending Physician: T within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, F. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 🗌 Yes မှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ♣ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural (Month, Day, Year) injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nulse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amended #26 per MD, RG FCHD 12/28/10 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day}₂4, 2010 JOHN ANDREW BONER December A M 3:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9103 O'possumtown Pike Frederick Frederick If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign West Virginia **Funeral** Months Days Hours Min 1 🔀 M 2 🗆 F Jumpeth, 24, Year 1937 73 234-54-4130 **Director** Usual Residence of Decedent 10b. County within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No WV Moatsville Barbour 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral Rt. #1 Box 219 U.S.A. 26405 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ö 1X Never Married 2 ☐ Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. "natural", Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Miner & Farmer Limestone Quarry & Farm permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robertus Franklin Boner Nora Gertrude Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beulah Wachter / Sister 9103 O'possumtown Pike, Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 💹 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Locust Grove Cemetery 12/28/2010 Moatsville, WV 4 Donation 5 Other (Specify) RÖBERT E. DATLEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET STREET, FREDERICK, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ neumorya disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner OP D Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to for as a consequence of a Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Physician should be set of this certificate has been signed by the attending physician and signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Wonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Sister's Residence Other: 1 Yes 2 100 မ 1 Inpatient 2 ER/Outpatient 3 DOA -5 ☐ Residence 6 X Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Natural 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MA D 66166 12 24 Kaza 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 801 Toll House Avenue, Suite B2, Frederick, MD 21701 Mudusar Raza, MD THIVA 31. Date filed (Month, Day, Year) 32. Regist ar's Signature

DHMH 17 Rev 7/2009

State

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DEC

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Patricia Ann Burroughs December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Hospice Care Rockville Montgomery 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Min. 1 □ M 2 🕱 F Hours 217-34-2055 936 74 July Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at Director Md. Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò tth and Mental Hygiene. 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be i Funeral 7512 Needwood Road 20855 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces ģ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify: If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bank Teller Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental h 2 William J. Nealis Edna F. Lowry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s of Health item 27 i William E. Burroughs, Sr/Husband 7512 Needwood Road, Derwood, Md.or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 ther (Specify) St. Luke's Cemetery 12/29/10 Derwood, Maryland ature of Funeral Service Licensee Name and Address of Facility
Muriel H. Barber Funeral Home 00 470 0. Box 5038, Laytonsville Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line mediate Cause (Final Acute Renal Failure Physician/ disease or condition resulting in death)) Medical Due to (or as a consequence of) Examiner Bradycardia Hypertension Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cirrhosis death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Pregnant at time of death ed by the a detached f 9 Unknown P.O. been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hepatic encephalopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔁 Unknown Records, Completed Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed? Yes 2 ≥ No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Division of Vital completed filled in by the funeral director, Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{S'Other (Specify)} \) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After tl Certificate: 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 24, 2010 D0060634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11160 Varnum St., N.E., #021, Washington, D.C. Bindu C. Joseph, M.D. 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Tyes 2 No

Marvland

01:15A M

2010

Black, White, etc

White

20882

Day

Year

Hospice

20017

Month

death?

1 ☐ Yes 2 ☐ No

Approximate

Interval Between Onset and Death

DHMH 17 Rev 7/2009

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ONALD Month М Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In vrs. last birthday) Birthplace (State or Foreign Country)
 NY 8 Date of Birth **Funeral** Months Hours 1 M 2 D F Mir 6/30/1929 094-20-4489 81 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location notified at 10d. Inside City Limits Director MD Anne Arundel Odenton 1 Yes XX No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be r Funeral 534 Saltoun Ave. 21113 USA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent Ever in U.S.
Armed Forces?

12 Yes 2 □ No 1956If Yes, Give
Year or Dates. 1970 Black, White, etc. 1 Never Married 3 Married þ Baltimore, Maryland 21215-0036 1 Yes 2x No Specify: White Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Merican injury or other traumatic event, the Merican Elementary/Seconday (0-12) College (1-4 or 5+) 4 Officer US Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Allen Camfield Amy Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Camfield Wife 534 Saltoun Ave. Odenton, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Surial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 Donation 5 Other (Specify) 12/29/2010 Crownsville, MD Maryland Veteran Cem Signature of Funeral Service Occasee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 851 Annapolis Rd. Gambrills, MD 21054 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy performed Yes 2 🖳 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 400 1 Inpatient ၉ 1 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 No Accident Investigation ☐ Accide
☐ Suicide 3 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) 841/81

State Registrar Name and address of person

31. Date filed (Month, Day, Year)

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DEFENSE HWY, ANDA POLIS, M.D. 21401

ho completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

1GHTFOOT-1H

10-09762 Michael Neil Casey

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar Certificate of Death		Reg.	No.	0 1 1 0 7
Physic		1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
Medical Exam	lliter	Michael Neil Casey 4a. Facility Name (if not institution, give street and number) 4b. City, To	wn, or Location of Deat	Month December 1	8, 2010 4c. County of Death	0345 hrs
		Bowie Health Center Bowie	WIT, OF EGGATION OF EGGA	(1)	Prince George	
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	1 Year If Under 24Hr	s. 8, Date of Birth((MM/DD/YYYY) 9. Birt	hplace (State or
Director		215-11-9580	Days Hours Mir	Feb. 20	, 1985 Foreign Co.	untry)Maryland
' any		10a. State 10b. County 10c. City, Town or Location	-			10d. Inside City Limits
Maryland 28a-f show	5	Maryland Prince Georges Bowie				1 Yes 2 No
Mary r 28a- ed at c	Director	10e. Street and Number 10f. Zip C			. Citizen of What Coun	try?
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eath w items ust be	Funeral	1 Never Married 2 Married Armed Forces? . If Yes, specify (of Hispanic Origin? (S Cuban, Mexican, Puerto	pecity Yes or No- p Rican, etc.)	14. Race - Americ White, etc.	can Indian, Black,
ifter d		1 Yes 2 No 3 Widowed 4 Divorced ITYes, Give Year 1 Yes 2 X	No specify:		Specify: Whi	te
5-0036 led within 72 hours afte Hygiene. I other than "natural? the Medical Examines	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Octubring most of working	ccupation (Give kind of		6b. Kind of Business/Ir	
36 in 72 h han 41 lical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			0110	
-00; d with grene ther th	mo;	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	GWC den Surname)	
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland death and Mental Hygiene. from 71 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Be	Kevin F. Casey	Barbara		,	
imore, MD 2121 Pages 1 and 2 should be fi ment of Heatth and Mental tant: If item 27 is marked or other traumatic event,	ပို	19a. Informant's Name/Relationship (Type, Print)			er, City or Town, State,	Zip Code)
e, MD I and 2 sho Health and item 27 is		Barbara D. Casey/ Mom 13501 Ivy 20a. Method of Disposition (Name			Oc. Location - City or 1	0
		crematory or other place)	*		,	, -
t. Pag tment rtant:		Burial 2 Acremation 3 Removal from State 4 Donation 5 Other Specify: 24 State Place Baltimore Washi	ngton 12	/22/2010	Laurel, MD)
Baltimore permit. Pages 1 Department of F Important: If i					ans Funera , MD 20715	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of complications that caused the death.				Approximate Interval
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries				Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of):				
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				_
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8760, ificate be ig physic s the bur		IF FEMALE: 23b. Was decedent pregnant in the part 12 greaths? 1 Live birth 2 Fetal death	3 Ectopic pregna		23d. Date of delivery Month Da	ay Year
Box 687 death certific the attending p	icia	past 12 months? 4 Pregnant at time of death 5 Other (Specify		andy	World Be	ay rour
BOY the death y the attr	Physician/	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying ca		Dan Diddehad		
ires that the signed by be detach	否	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	iuse given in Part I.		cco use contribute to th	
of Vital Records, ng Physician: The law require the this certificate has been si neral director, page 2 should b	Completed			24a. Was an		ppsy findings available
Reco The law cate has	E E			autopsy performed	d? death?	mpletion of cause of
nn: The striffication, pa			Place of Death (Check		No 1 ✓ Yes	2 No
Vita hysicia this ce	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA	Other ₄ Nursin	ng Home 5 Res	sidence 6 Other:	
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 Hospital or Attending Physician: The law requires that the death certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the	tion:	1 Natural 5 Pending Dec 18, 2010 0210 hrs	. Injury at Work? ☐ Yes 2 ✔ No	28d. Describe how Driver auto fixe	injury occurred ed object collision	1
Division tal or Attendius after death. al Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, of		or Town, State	et and Number or Rura	
Ospital bours a uneral 1		4 Homicide determined (Specify) Major Road / Highway		7000 Block Race	Track Road, Bowie	
the Hos hin 24 h the Fur npletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my op				
To the within To the comple	Me	and manner stated. 29b. Signature and title of certifier 29c. Li	icense number	29	d. Date signed (Monti	h, Day, Year)
		Usignito, The U.S. 16	C.M.E.	D	ecember 18, 201	10
	Ì	30. Name and address of person who completed cause of death (Item 23a)				
			t, Baltimore, MD	21201		
St Regis	tate	31. Date filed (Month DEC 27) 0 2010 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 18 Physician/ 4:03 P 2010 Judith Gwendolyn Carrington December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Baltimore Gilchrist Center Hospice Care 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8 Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 Days Min 1273071938 Arkansas Director 71 431-64-8590 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🙀 No Maryland | Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21037 USA 1607 Cliff Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Tes 2 No Specify: Specify. 3 Widowed 4 N Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Giant Food 12th Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Jewel Thaver Frank Marion Pounders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1607 Cliff Drive, Edgewater, MD 21037 Catherine A. Guyer/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12/22/10 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Cemetery 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Ph_sician/ MONIC) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). Exami signed by the attending physician and dbe detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been a Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate has 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: We 1 🗌 Yes 2 **No** Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature of person who comple ed cause of death (Ite m 23a) (Type, Print) 6701 N. Charles Street, Baltimore, MD 21204 Rilev

DHMH 17 Rev 7/2009

State Registrar DEC 2 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ COUNCELL 9:15A M **DECEMBER** 2010 EVELYN U. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner QUEEN ANNE'S QUEEN ANNE COUNTY HOSPICE CENTER CENTREVILLE 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** (Month, Day, Year) AUG.31,1922 MARYLAND 88 Director 217-12-4135 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director **OUEEN ANNE** CHESTERTOWN 1 ☐ Yes 2 🗶 No MD 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral USA 21620 108 HOLLY COURT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 ▼ Widowed 4 □ Divorced WHITE Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry th and Mental Hygiene.
It is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ FLORENCE KEYSER ROBERT L. USILTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. 109 HOLLY COURT, CHESTERTOWN, MD 21620 R. ALLEN COUNCELL/ SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State WOODLAWN MEMORIAL PARK 4 ☐ Donation 5 ☐ Other (Specify) EASTON, MD 21. Signature of Funeral Service License 22. Name and Address of Facility or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on pach line. Approximate Interval Betwe Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to for as a consequence of if any leading to immediat cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Conditionsalis 1 Yes 2 1 Ho 3 Probably 4 Unknown Completed 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) Residence 6 \(\text{Other} \) Other (Specify) 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 31. Date filed (Month, Day, Year)

Kiss

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32. Registrar's Signature

51666 ding

MUS

29d. Date signed (Month, Day, Year)

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Decent 23, 2010 Ernest Edward Cooper 12:02 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Southern Maryland Hospital Clinton Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min Dec 25, 1924 247 20 6083 Ma&&fit^rGeorgia Director 85 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location ld be filed within 72 hours after death with the Maryland Mental Hygiene. Director 10d. Inside City Limits Maryland Prince George's Clinton 1 Tes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8629 Dangerfield Place 20735 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 √2/Yes 2 □ No If Yes, Give Year or Date 43 −45 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Office 0 Elementary/Seconday (0-12) College (1-4 or 5+) 12 GAO General Accounting Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jack Cooper, Sr. Myrtle Allen permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8629 Dangerfield Place, Clinton, MD Carolyn Wood (daughter) 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec 29, 2010 Brentwood, Maryland Fort Lincoln Cemetery 21. Sign ture of Funer I / er ice/Ligensee 22. Name and Address of FacilityLee Funeral Horre, Inc. 6633 Old Alexandria Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ Pheumoni disease or condition Medical resulting in death) Oronury of): Examiner Sequentially list conditions, if any action of the cause. Enter Underlying Cause (Disease or iinjury Examine the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 No has been signed by the e 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Peripheral Vascular disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate har funeral director, page performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospita 1 ☐ Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending work Accident Suicide Investigation 1 Yes 2 No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Medica 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature ar D0052999 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1CRIOTI 10403 Hospital Drive G-06 CLINTON MD20731 RAHIMIAN ALI MD 32. Pagistrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend#8and#14perfuneralhomeccdonf/9999 Peath 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** <u>Solita Villacrusis Clark</u> December 18, 7:05 P /Medical 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2320 Woodberry Drive **Bryans** Road Charles 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 5. Social Security Number 7. Age (In vrs. last birthday) 1 □ M 2 X F Yrs. Director 74 lovemver 3, 1986Philippines 266-96-8948 Usual Residence of Decedent November permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Modical Francisco. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director Maryland Charles Bryans Road 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2320 Woodberry Drive 20616 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Filipino
Specify: Philapino 1 ∐Yes 2 XX No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify. Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Technologist Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lucas Villacrusis ၉ <u>Epiphania Caranzo</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2320 Woodberry Drive, Bryans Road, Maryland 20616 ce of Disposition (Name of Date 20c. Location - City or Town, State <u>Richard Clark/ Husband</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Charles Cemetery Dec. 23, 2010 Indian Head, MD. 22. Name and Address of Facility 21. Signature of Funeral Service Excenses Huntt Funeral Home Møllaa 3035 Old Washington Rd. Waldorf, MD. 20601 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to or as a consequence of the burial-tran and Due to (or as a consequence of): s been signed by the attending physician should be detached for use as the buria Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 sh 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 ☐Yes 2 ☐No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 5 PResidence 6 ☐ Other (Specify) funeral 27. Manner of Death 1 ☐ Natural 2 ☐ Accident e Hospital or Attending Pt 124 hours after death. e Funeral Director: After th 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier HCCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RB Ste 102 h co Old Washing Mathe gistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 8, 20b-c, FH, TCHD, rs, 12/17/10 Certificate of Death Amended, # 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10 /Medical Darlene Collins 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Dorchester Cambridge 821 Park Lane If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 2 = a1 2 - 5 9. Birthplace (State or Foreign Country) **Funeral** Hours 1 M 2 F 216-56-1971 02-1201955 Virginia 55 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Show notified at 1. Yes 2 □ No Md. Dorchester Director Cambridge 23a or 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or edical Examiner must be 821 Park Lane 21613 Funeral US∆ 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Black Completed the Medica! 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clayton Crab Co. 11 Production Worker . Pages 1 and 2 should be filed wi ment of Health and Mental Hygier tant: If Item 27 Is marked other th jury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Collins Lillian Savage 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 Garden Ct., Federalsburg, Md. 21632 Lillian Collins / mother Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Federal Hill Cem Federalsburg, MD Hurlock, Md. 12-10-10 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department or Important: If any injury or 4 Donation \$ ☐ Other (Specify) Petersburg Cem. 22. Name and Address of Facility
Bennie Smith Funeral Home 21. Signatur eral Service Licensee 516 S.Main St., Hurlock, Md. 21643 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 10 4 YS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and burial-tran Due to (or as a consequence of) Box 68760. physician Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. the 9∏Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? certificate 1 Yes 2 No or Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ၉ he Hospital or Attending Ph n 24 hours after death. he Funeral Director: After th pletely filled in by the funeral funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

rn St., Cambridge, md. 21613

10-09704 Harold R. Cecil

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Funeral Director		5. Social Security Number 212-24-9207	6. Sex	2F	7. Age (In yrs. 82	last birth	hday) Yrs.	If Under Months	1 Year Days	If Under Hours		8. Date of B 09/10				nplace (State or Intry) W.d.	
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760, cate be executed physician and the burial - transi	Medical	UNPENDED		MENDED													_
68 certif	Physician/M	IF FEMALE: 23b. Was decedent pregnant in t past 12 months? 1 Yes 2 No 9 Un	ne 2 1 known 9	Live b	nant at time of d	2		l death er (Specif		Ectopic p	pregnand	ey	23	ld. Date of o	_	ay Year	
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715	We	29b Signature and title of certific	em	\bigcirc				- 1	icense r					Date signe		th, Day, Year) 10	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year KURGER DONOYAN NOBLE 201 M Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 □ F Months Days Hours (Month, Day, Year Country)
Maryland Director 212-24-3039 81 1929 Jan. Usual Residence of Decedent or 28a-f show 10a. State 10b. County 72 hours after death with the Maryland Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11828 Robinwood Drive U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ₩ No Maryland 21215-0036 1 Yes 2 No Specify: 3 🗆 Widowed 4 🗀 Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Frank Burger Elizabeth Zinkond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sho Department of Health an Important: If item 27 is 11828 Robinwood Drive, Hagerstown, MD 21742 Betty J. Burger / Wife Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Rest Haven Cemetery 12/30/2010 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland . Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Retween SHOCK Immediate Cause (Final SEPTIC Onset and Death Ph sician/ disease or condition resulting in death) UNKHUNN Medical Due to (or as a consequence of) **Examiner** PHEUMONIA PIRATION Sequentially list conditions Examine if any leading to intractic cause. Enter Underlying Cause (Disease or linjury INTESTINAL DESTRUCTION Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ATRIAL FIBRILLA 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? certificate 1 Yes 2 No ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation the within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Gettifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D0069606 DECEMBER, 28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD KODUAH 324 E. ANTIETAM ST. #306 HAGERSTOWN MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

JAN 1

10-10121 Michael Clifford

Please Type or Print in	ı Black Indelible Ink.	Ensure All Copies	Are Legible.	\cap	42	5	5
State of Maryla	and / Department of He	ealth and Mental Hygi	iene	U	To See	9) '

		I- For State Registrar		Cer	tificate o	f Death			Reg	J. No.		
Physicia	an/	1. Decedent's Name (First, Midd		M	ate of Death onth	Day Year		Time of Death 1719 hrs				
Medical Exami		MICHAEL (-	4h City Tourn or I	coation of D		ecember	30, 2010 4c. County o	1	17 19 1115
		4a. Facility Name (if not institution Meritus Medical Cent.		mber)		4b. City, Town, or L Hagerstown	ocation of D	Jeatn		Washing		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 2	24Hrs. 8.1	Date of Birth	(MM/DD/YYYY)	9. Birthpla	ace (State or
Director		220-64-6601	1XM 2 F	55	Yrs	Months Days	Hours	Min.	9/19/19	55	Foreign Country	y) MD
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5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.		492 MIMOSA DRIVE			<u> </u>	25404		2 (2		USA LAA Basa	A	Indian Diani
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within jene.	E	12 17. Father's Name (First, Middle			DOCK	LOADER	O Matheda A	lome (Fire	t Reiddlo Rei	aiden Surname)		00.
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	0	FRANK CLIFFORD	, Last)			I.		NNA G		arden odmanie,		
D 2121 should be fill and Mental I 7 is marked	O B	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailin	g Address (Street				er, City or Town	n, State, Zip	Code)
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Ore, M es 1 and 2 of Health If item 2		20a. Method of Disposition 1 Burial 2 Cremation	n 3 Removal fr		Place of Dispos crematory or ot	sition (Name of cem her place)		Dat JAN. 7.		20c. Location -	City or Tow	n, State
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Baltimo permit. Page Department o Important: injury or ott	ı	21. Signature of Funeral Service	BROWN I	FUNERAL	HOME, PO	BOX 8	21.					
		10 Deet (-170	(40	Do not opton	P7 W. KING	ST. MA	ARTINSP	RIRG W	V 25402		pproximate Interval
Physician /Medical		failure. List only one cause	Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial failure. List only one cause on each line. The disease a Hypertensive Atherosclerotic Cardiovascular Disease									Between Onset and Death
Examiner	í	Immediate Cause (Final disease or condition resulting in death)		consequence of		iovascular Dise	ease	_			-+	
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	iner	if any, leading to immediate cause. Enter Underlying Cause		consequence of	f):						_	
44	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of	f):							
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<u>a</u> <u>a</u> e	/Medical	UNPENDED	AMENDED									
		IF FEMALE: 23b. Was decedent pregnant in t		outcome of pregi pirth		etal death 3	Ectopic pr	regnancy		23d. Date of o	delivery Day	Year
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fs, F quires en sign	ted	Wordid Obesity, Diak	Jeles					— -	24a. Was ar			y findings available
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tal Rec	S						(D (O).	1	Yes 2	✓ No 1	Yes	2 No
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Division of Vital Records, P.O. ral or Attending Physician: The law requires that the ra after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacled.	P.	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury	28b. Time of		at Work?			ow injury occurre		
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Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		(Check only	hysician: To the bes									use(s)
To th withii To th	Medical	one) 2 Medicai Exa 29b. Signature and title of certifi	and manner s		naroi investiga	29c. License		- at the		29d. Date signe		
	•	C Congression of the or continu	1 1/			O.C.N				December:		
		30. Name and address of person	who completed cause	se of death (Item	23a)					_		
			puty Chief Medic			Baltimore Stree	et, Baltim	ore, MD	21223			
	ate	31. Date filed (Month, Day Year)	4 2011 32.	gistrar's Signatu	ire /	ukal						
Regis	rar	JAN 4	1 4UIII AA	your ,	1496	NE MILE						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month)548 AM 010 Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1718 Urby Drive Crofton Anne Arundel 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 110M 2 D F Months Min. 220-22-2560 Director 81 19 Yrs 1929 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits ms 23a or 28a-f s must be notified Maryland Anne Arundel Crofton 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1718 Urby Drive 21114 U. S. A. 12. Was Decedent Ever in U.S permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 X Married ģ 2 No Baftimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1951-53 1 ☐ Yes 2 X No Specify: White 3 Divorced 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Lawyer Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Joseph J. Dovle Mary Meyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Doyle/Wife 1718 Urby Drive, Crofton, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State La kemont Memor al 4 Donation 5 Other (Specify) 12/20/2010 Davidsonville, MD Gardens 21. Signature of Funeral Service Licensee Robert E. Evans Funeral Home, 22. Name and Address of Facility Ken / Krei 16000 Annapolis Road, Bowie, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between IETAS Immediate Cause (Final nset and D at C Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or iinjury that initiated events and tran resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) ____ Pregnant at time of death Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 2 🗌 No Yes 2 1 🗌 Yes Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes Other: 2 No ျပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Auxoritin 24 hours after death.

To the Funeral Director: After a consisted filled in by the fur 1 Natural 5 Pending injury work? ☐ Accident ☐ Suicide 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 39. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JENEVIEVE LIGHTFOOT-TAYLOR, 45 DEFENSE HWY, ANNAPOLIS, M.D. 21401 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

of Vital

Division

State of Maryland / Department of Health and Mental Hygiene [] State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mary Elizabeth Ellis Physician/ December 2010 3:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign ial Security Numb **Funeral** ^{Year)}19<u>31</u> 216-28-5728 1 □ M 2 🔀 F Months Days Hours Min. June 14 Maryland **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Directo Maryland Anne Arundel Annapolis XX Yes 2 No 10g. Citizen of What Country?
U.S.A. 10e. Street and Number 10f. Zip Code 217 Gibson Road 21401 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White "natural", Completed 3 XWidowed 4 ☐ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 hand Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas Nelson Dudley Margaret Kopfle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Dalene Lupinek/daughter . Page 1 and 2 sl ment of Health a tant: If item 27 is 310 Taylor Avenue Annapolis, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Cemetery 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it 5 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 12/30/2010 Annapolis, Maryland injury (4 Donation 5 Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home Signature of Funeral Service Licenses 10 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one caus Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown 1 ☐ Yes 9 ☐ Unknown been signed by the should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page PMENT 1 ☐ Yes 2 ☐ No Yes 2 Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Yes မ Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) -Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 0060225 person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Parkway Annapolis, Maryland 21401 State 2 barks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] | [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December Day 25, Physician/ Elva H. Elzey 2010 8:46 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Annapolis 4c. County of Death Anne Arundel **Examiner** Anne Arundel Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Hours 7 /2/1927 (Par) Mary Tand 220-20-2094 83 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Marlal Hygiene. Important: If the 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Annapolis Maryland Anne Arundel 1 ☐ Yes 2 🏝 No 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zip Code 21401 by Funeral 2625 Rigging Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12, Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Manager Be 18. Mother's Name (First, Middle, Maiden Surname) Helen Donaldson 17. Father's Name (First, Middle, Last) မ Vincent Hart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15650 Bushy Park Rd, Woodbine, MD 21797 19a. Informant's Name/Relationship (Type, Print) Barbara Shaw - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12/29/2010 Baltimore, MD Baltimore Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licenses 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year been signed by the should be detached ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Xes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death? Yes 2 2 No 1 Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' 1 Yes 2 -No Other: ၉ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and fife of of rifier 29d. Date signed (Month, Pay, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira Weinstein, MD 600 Ridgely Avenue Annapolis, MD 21401 31. Date filed (Month, Day, Year) 7 2010 State back Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	Please					-	s Are Legible	
	or ate egistrar	State of Ma	aryland / De _l Ce	partment of leartificate of l			giene / U L Reg. No.	42659
Physician/ Medical	edent's Name (First, Middle, La Raymond	Lo	Evan			2. Date of Dea Month	Day Year 23 201	3. Time of Death
Examine	sility Name (if not institution, give				r Location of Dea	ath	4c. County of Dea	
	te Arundel Medial Security Number 6.5		e (In yrs. last birthday	Annapol If Under 1 Year			Anne Arur	rthplace (State or Foreign
Director 215	5-28-1734 Residence of Decedent	M 2 □ F	81 Yrs.	Months Days	Hours Mir		, 1929 Mar	yland
aryland arishov (filed at Mox.)		undol	10c. City, Town or I					10d. Inside City Limits 1 ☐ Yes 2 ※ No
10e. St	yland Anne Ar	under	Lugewate	10f. Zip Code			10g. Citizen of What C	ountry?
s 23a sunst b Inst b Inst b	8 Southport Dri	ve		210	37		US	SA
8 E E L	rital Status] Never Married 2 🙀 Married] Widowed 4 🗌 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 IX If Yes, Give Year or Dates.		. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🎛 No	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.
within 72 hours after within 72 hours after giene. ier than "natural", o ier than medical Exam	15. Decedent's E (Specify only highest gr	ade completed)	(Giv	edent's Usual Occup e kind of work done DO NOT use retired,	during most of wo	orking	16b. Kind of Business	Industry
vithin vithin gliene.	mentary/Seconday (0-12)	College (1-4 or 5)+) _	urance Age			Insuranc	e
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Kay	mond L. Evans,	Sr.			Emma F	oard oard		
Maryland (17. Fat Ray) 17. Fat Ray 19. Ir Lannatic event at transmit event e	nformant's Name/Relationship (l zabeth L. Evan						r, City or Town, State, Z	
Baltimore, semit. Page 1 and mportant if item mportant: if item mp	ethod of Disposition Burial 2 🛣 Cremation 3		cemetery, cr	position (Name of ematory or other pla		Date	20c. Location - City o	
Iltin	Donation 5 Other (Special Donation 5 Other Other Other (Special Donation 5 Other			rematory 22. Name and Addre			Kalas Fune	
Bany Berry and Bany Bany Bany Bany Bany Bany Bany Bany	Muller					_	Edgewater,	
Physician/ simmed disease	Part 1. Enter the disease, or com hock, or heart failure. List only of diate Cause (Final se or condition	plications that caused one cause on each line	the death. Do not e					Approximate Interval Between Onset and Death
Examiner	ng in death)	Due to (or as a	a consequence of):	F	+ 7 N	n HAGE		Jen
Seque de la cause	entially list conditions, leading to immediate . Enter Underlying (Disease or iinjury	Due to (or as a	a consequence of):					/
cian and that in resulti	itiated events ng in death) Last	Due to (or as a	a consequence of):					
rate bo		d						
ath ath for cia	ALE: as decedent pregnant the past 12 months? Yes 2 □ No □ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant at 9 Unknown	2 Fetal death 3	☐ Ectopic pregnan ☐ Other (specify) _	су		23d. Date of de Month	elivery Day Year
ords, P.O. Be v requires that the de should be detached should be detached and the should be detached the should be detached and the should be detached the shou	Other significant conditions of	ontributing to death b	ut not resulting in the	underlying cause gi	ven in Part I.		obacco use contribute t	o the cause of death?
require						24a. Was		utopsy findings available
Division of Vital Records, as after death. Is after death. In Director. After this certificate has been signed in by the funeral director, page 2 should be a in Certificate. To Be Completed.						- autor	osy prior to death?	completion of cause of
exa certifii an ician:	s case referred to medical uminer?	Hospital:		Oth	lace of Death (Ch			
Physic or this	Yes 2 No	28a. Date of injur		ent 3 🗆 DOA	4 L Nursing		dence 6 Other (Spe	cify)
nding Ph ath. :: After thi e funeral	Natural 5 Pending Accident Investigatio	(Month, Day	(Year) injury	wor	ć? IYes 2 □ No		, , , , , , , , , , , , , , , , , , , ,	
ivision of lor Attending P after death. Director: After t in by the funera lin by the funera Certificate:	Suicide 6 Could not be Homicide determined	28e. Place of Injubuilding, etc	ry - At home, farm, s . (Specify)	street, factory, office		28f. Location (S City or Tow	Street and Number or Ru vn, State)	ıral Route Number,
Division To the Hospital or Attendin, within 24 hours after death. To the Funeral Director: Aft. completed filled in by the fun Medical Certifical	Check 2 Medical Exam	iner: On the basis of ex	kamination and/or inv	estigation, in my opini	on, death occurred	d at the time, date a	use(s) and manner as stand place, and due to the	cause(s) and manner stated
of the of	nly one) 3 Certifying Nur gnature and title of certifier	se Practioner: To the	best of my knowledge	e, death occurred at the			e cause(s) and manner as 29d. Date signed (Mont	
30,13	mi chail	2 De	wan	D 2	1438		Decem	ver 23 2010
0	ne and address of person who	PENTAN	eath (Item 23a) (Type	Print) -YENSE	Hwy A	NNAPOU	1) MDLIY	0/
State ^{31. Dat} Registrar	e filed (Month, Day, Year) DEC 2 7 20	32. Fégistra	r's Signature	back	,			

Records, Division of Vital Hospital or Attending npleted f

Box 68760

P.O.

State

KRISHAN MATHUR, M.D. 31. Date filed (Month, Dav. Year)

2 | 3 |

29b. Signature and title of certifier

(Check

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3500 OLD WASHINGTON ROAD, SUITE 102, WALDORF, MARYLAND

32. Registrar's Signature Seneur

Registrar DHMH 17 Rev 7/2009 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D28352

29d. Date signed (Month, Day, Year)

DECEMBER 28, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 24,2010 Friedman Sau1 9:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4237 Kings Road Anne Arundel Edgewater Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 108-20-6332 1 XM 2 - F 81 03970471929 Newmyork Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Edgewater 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4237 Kings Road 21037 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. was Decedent Ever in U.S Armed Forces? 1 XYes 2 No If Yes, Give 50-52 Year or Dates. Black, White, etc. 1 Never Married 2 X Married δ 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " யுe. ம்0 NOT use retired) Journalist Elementary/Seconday (0-12) College (1-4 or 5+) Newspaper 12 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Friedman Evelyn Sanftman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn B. Friedman Spouse 4237 Kings Road Edgewater,MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory or other place; 12/26/2010 Glen Burnie,MD Signature of Funeral Service License 22. Name and Address of Facility Hardesty Funeral Home P.A.Annapolis, MD 21401 ball 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Fhysician/ Stomach disease or condition resulting in death) o months Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate

Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 1 Yes 2 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 \sum Yes 2 No 3 ☐ Probably 4 ☐ Unknown this certificate has been ral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 1 Yes B B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No ပ 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After completed filled in by the funer

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

12 Miles

Medical

Suicide

4 Homicide

29a. Certifier only one)

State

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ine wer , MD

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Parking #210,

MO Werner.

6 Could not be

determined

Day, Year) DEC 2 8 2010

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 20, 2010 **Physician** Kathryn Ann Farrell 8:05 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Mandrin Hospice House Harwood Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7/17/1943 6 Sex Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 🗗 F Months Hours Min 215-40-5649 67 **Director** Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28c.f.-rany injury or other traumatic event, the Market and 100c. 10h County 10a State 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis Director 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 McDonough Road Funeral 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 1 □Yes 21 No <u>چ</u> Specify. 3 X Widowed 4 □ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Medicine 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Matthew Keller Theresa Carter မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly Meissner - Daughter 7061 River Oak Ct, Clarksville. MD 21029 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Marial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cem. 4 ☐ Donation 5 ☐ Other (Specify) 12/28/2010 | Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Luna (ancer **Physician** yeary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause that in defining Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ■ No Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been si 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 2 🗆 No 1 □ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? al or Attending P after death. I Director: After I d in by the funera 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date, signed (Mpnth, Day, Year) 2003 Medical PKWa Annapolis, Md. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) selonick, mo 31. Date filed (Month, 32. Registrar's Signature Day Year) State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Day 23, 2010 2:36 Ам Eleanor R. Finley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Anne Arunde1 **Examiner** Annapolis Ginger Cove Health Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 94 9/27/1916 ar Pennsylvania 197-03-3478 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Annapolis Marvland Anne Arundel 1 ☐ Yes 2 🏝 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21401 Funeral 4000 River Crescent Drive items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. and Mental Hygiene. is marked other than "natural", or ð 1 Never Married 2 Married 1 ☐ Yes 2 ☐xNo If Yes, Give within 72 hours after 1 Yes 2 No Specify: Specify: White Completed 3 Nidowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Barratt မ John H. Reading permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6604 Westmoreland Ave, Takoma Park, MD 20912 Elizabeth Finley - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State injury or 12/29/2010 Baltimore, MD 4 Donation 5 Other (Specify) Signature of Funeral Service License

Museum T. Wille 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregn 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 - Fetal death in the past 12 months? Month Day Year Pregnant at time of death signed by the at be detached for 9 Unknown Part II. Other significant co. itions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? completed filled in by the funeral director, 25. Was case referred to n 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Tyes မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Matural 5 Pending Investigation Could not be 2 🗌 No 1 Yes Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 7 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 5: 23A M December 16, 2010 <u>Joyce A. Fiori</u> Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Doctors Community Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Funeral New York (Month, Day, Year) 78 088-24-0660 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Marvland Prince George's Bowie 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10q, Citizen of What Country? Funeral USA 20715 12110 Millstream Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: White If Yes Give Specify: Completed 3 Divorced 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Home 12th Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle, Last) ည Helen P. Creamer Robert R. Fox 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 12110 Millstream Drive, Bowie, MD 20715 Important: If item 27 any injury or other tr once. Julius J. Fiori/ Husband 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Signat Surface Certain Surface (Specify) Resurrection Cemetery 12/22/10 Clinton, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Pheumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ardio my Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Chronic Obstin To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No for Month 4 Pregnant
9 Unknown Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death. To the Funeral Director: Af ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 12/17/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAW HAM ND 20706 LUCK ROAD

DHMH 17 Rev 7/2009

State Registrar

50N

32. Redistrar's Signature

M.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 42655

		1	For State Registrar			,	Cert	ificate of L	Death		Reg. No.	
	Dharisis		1. Decedent's Name (First, Midd	e, Last)						2. Date of Dea Month		3. Time of Death
	Physicia Medic	al	David Lee Fike							12		5 0525 M
	Examin	er	4a. Facility Name (if not institutio					•	r Location of Death		4c. County of I	
• 1			WMHS Regional				intholous)	Cumber 1 If Under 1 Year		8. Date of Birt		Birthplace (State or Foreign
	Funeral Director	1	5. Social Security Number 235-54-8181	6. Sex 1 🔀 M 2		(In yrs. last b	Yrs.	Months Days	Hours Min.	Sept.	3' 1934 V	Vest ^{ry)} Virginia
<i>*</i>	T ow	. I	Usual Residence of Decedent 10a. State 10b. Count			10c. City. To	um or Loo	ation.				10d. Inside City Limits
	yland -f show ed at	흥		,								1 🗆 Yes 2 🔀 No
	e Ma r 28a notifi	Director	MD Garr	<u>ett</u>		Friend	dsV11	10f, Zip Code			10g. Citizen of Wha	
	ith th	틸	618 Green Gabl	os Pd				21531			USA	,.
	ath w	Funeral	11. Marital Status	12. W	as Decedent E	ver in U.S.	13. W	as Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	14. Race -	American Indian,
9	or it	by	1 Never Married 2 🕱 Ma	arried 1	rmed Forces?	No			an, Mexican, Puerto	Hican, etc.)		White, etc.
200	ural", ural", u Exa	je g	3 Widowed 4 Divorce	d Y	Yes, Give ear or Dates.			Yes 2 X No				Wh <u>ite</u>
<u>2</u>	"2 hou "nat edica	Completed	15. Deced (Specify only high	ent's Educationest grade cor		16	(Give k	ent's Usual Occup ind of work done	during most of work	ing	16b. Kind of Busin	ness Industry
12	ithin 7 ene. • than the M	등	Elementary/Seconday (0-12)	C	ollege (1-4 or 5	i+)		NOT use retired, Driver/			Trucking	g/Dairy
D D	led w Hygi other ent, t	Be	17. Father's Name (First, Middle,	Last)					T	ne (First, Middle,	Maiden Surname)	
an	be fil lental rked iic ev	욘	Bliss Fike						Faye Mo	yers		
агу	hould and N is ma iumat		19a. Informant's Name/Relation	ship (Type, Pr	int)						r, City or Town, Stat	
Σ	nd 2 sealth an 27 i		Anna C. Fike/V	√ife		(618 0	reen Gal	oles Rd.,	Friends	sville, M	
ore	of He of He or oth		20a. Method of Disposition 1 X Burial 2 Crematio	n 3 □ Remo	oval from State	00000	stant aram	sition (Name of atory or other pla	cal i	Date	20c. Location - Ci	
Ě	Pagement ment tant: jury o		4 Donation 5 Other			Bloom	ning I	Rose Cem	etery Dec	. 18, 2	Olo Frien	ndsville, MD
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f shon amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	bicensee	(0)		22. P	Name and Addre	ess of Facility 130 275, Gran	tsville.	neral Ho , MD 215	36
	21100	-	23a Part 1 Enter the disease	pr complication	ons that caused	the death. D						Approximate
shock, or forart failure. List only one cause on each line.												Interval Between Onset and Death
	mysician/ Medical		disease or condition resulting in death)		- /							
	Examiner			le de la constante de la const	C	aHU	10 MCP	hul 4'5		2 days		
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. —	Due to (or ae							
	cuted nd ransit	Examiner	Cause (Disease or iinjury that initiated events	c								
	e exection and an anial-t		resulting in death) Last		Due to (or as	a consequenc	ce ot):					
8760	tificate be executed ng physician and as the burial-transit	Medical	1	d								
687	£ 5.8		IF FEMALE: 23b. Was decedent pregnant	23c. II	f <u>ye</u> s, outcome	of pregnancy	_				23d. Date	of delivery
Box	atten atten for u	iciar	in the past 12 months?	1 4	☐ Live Birth ☐ Pregnant a	2 ☐ Fetal de	eath 3 🗀	Ectopic pregnar Other (specify) _	ncy		Montl	
B	the de by the ached	Physician/	9 🗆 Unknown		Unknown							
P.0.	the Hospital or Attending Physician: The law requires that the death cert fin 24 hours after death. the Funeral Director: After this certificate has been signed by the attendir the Funeral Director. After this certificate seem signed by the funeral director, page 2 should be detached for use mpleted filled in by the funeral director, page 2 should be detached for use	by F	Part II. Other significant condi RIG FOOL UN LUUS LO	tions contribu	uting to death b	out not resulting	ng in the u	nderlying cause o	iven in Part I.	23e. Did t		ute to the cause of death?
ds,	equire	Completed by	11010000	1)	Maria	109 .	- 6	-/1/4	Coule	1		
S	law re nas b	ם	LULY LO	100	100	CEV	60-	<i>()</i> \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	d Cherry	24a. Was auto	psv pri	ere autopsy findings available or to completion of cause of ath?
æ	: The cate ;		ucudin							1 Tes		Yes 2 No
ita	Physician: The law this certificate has al director, page 2 s	Be	25. Was case referred to medic examiner? 1 \(\sum \) Yes 2 \(\sum \) No	Hospi	tal:		(O t 1)	_ Ot	Place of Death (Checher:		damas C T Othor	(Casaita)
<u></u>	Phys r this gral di	e 일	27. Manner of Death	2	8a. Date of inju		b. Time of	28c. Inju	ıry at		dence 6 Other how injury occurred	
n c	nding ath. :: Afte e fune	cat	1 ☑ Natural 5 ☐ Pend 2 ☐ Accident Inve	ding stigation	(Month, Da	y, Year)	injury	M 1 L	rk? ☑ Yes 2 ☐ No			_
Division of Vital Records,	r Atter er deg rector by th	Certificate:	3 🔲 Suicide 6 🗀 Cou	ld not be 28	8e. Place of Injude	ury - At home	, farm, stre	eet, factory, office		28f. Location (or Rural Route Number,
<u></u>	ital o Ins aff ral Di	a C										
	Hosp 24 hou Funel eted fil	Medical	(Check 2 Medica	I Examiner: C	on the basis of e	examination an	nd/or invest	tigation, in my opin	nion, death occurred	at the time, date :	ause(s) and manner and place, and due to an cause(s) and man	o the cause(s) and manner stated.
	To the Hospital or Attending Phys within Eu hours after death. To the Funeral Director: After this completed filled in by the funeral di	Σ	only one) 3 ☐ Certifyi 29b. Signature and title of certifyi		actioner: To the			29c. Licen	se number		ne cause(s) and mann 29d. Date signed (Month, Day, Year)
	->-0		much	ruh	KIL	MM	1	DC	00531	58	12/1	5/0010
	7	8	30. Name and address of person			leath (Item 23	Ba) (Type, F	Print)	1.	- 1-	12/1 mu-	1. 101
	4	VA		to ske				wile	unl	11100	a one-	91009
	Sta Registr		31. Date filed (Month, Day, Year		33. Hegistr	ar's Signature	La	Kel				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ VIRGINIA ROSE **FORTENBERRY** DECEMBER 2010 6:48 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death TALBOT 13331 OLD WYE MILLS ROAD **WYE MILLS** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 🗆 M 2 🗶 F Days Hours Min. JUNE 14, 427-38-9387 82 1928 NORTH DAKOTA Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No TALBOT WYE MILLS MD 10e. Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral er than "natural", or items 23 the Medical Examiner must 13331 OLD WYE MILLS ROAD 21679 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 X Never Married 2 Married Maryland 21215-0036 1 Yes 2X No Specify. If Yes, Give Specify. Completed 3 Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) CENTRAL INTELLIGENCE AGENCY FEDERAL GOVERNMENT 12 of Health and Mental Hygie If item 27 is marked other Ir other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ pe **JOHN FOXWORTH FORTENBERRY** BLANCHE SCHMITZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NEPHEW Department of Health ar Important: If item 27 is any injury or other traus ROBERT J. SMOLOSKI, M.D. 13331 OLD WYE MILLS ROAD WYE MILLS, MD 21679 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State LONG BEACH CEMETERY 12-22-2010 LONG BEACH, MS 4 ☐ Donation 5 ☐ Other (Specify) e of Fune 21. Signatu 22. Name and Address of Facility 200 S. HARRISON ST. EASTON, MD FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause o Immediate Cause (Final .Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical sema Box 68760 use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ signed by the atte in the past 12 months Month Day Pregnant at time of death Yes 2 LAK 9 Unknown 9 Unknown P.O. Part IL. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Viatetes Division of Vital Records, 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No 1 Yes funeral director, Be 25. Was case referred to predical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Hospital: 1 Ves မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No death Accident Investigation after death the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f Location (Street and Number or Rural Route Number determined within 24 hours a To the Funeral D Medical 🖫 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie TUS completed cause of death (Item 23a) (Type, Print) 30. Name and OSKI

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

21 2010

	1	For State Registrar				-	tificate of	Health and Death	·	Reg. No.	2010	4266	7
Physician Medica		1. Decedent's Nam	e (First, Middle, La.	st)	SAF	RVE.	1		2. Date of De Month	ath 2 S	2010	3. Time of Death	VI _
Examine		4a. Facility Name (if	not institution, give	street and number)				or Location of Deat	h		County of Deat		
		1182 Nane 5. Social Security N		20V 7 A	no (In una le	ast birthday)	Crowns If Under 1 Year		. 8. Date of Bir		ne Arun		
Funeral Director		037-24-7	852	M 2 🗆 F	73		Months Days	Hours Min.				thplace (State or Foreig untry) RI	'n
Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ig	10a. State	10b. County	1 1	10c. Cit	y, Town or Lo						10d. Inside City Limit	
r 28a	ě	MD 10e. Street and Nur	Anne Aru	indel		Crown	10f. Zip Code			10- 011-	en of What Co		10
23a o st be	Funeral Director	1182 Nan					210	132	-	rog. Gilizi	USA	ditty?	
r mn	<u></u>	11. Marital Status	cy Lane	12. Was Decedent	Ever in U.S	S. 13. V		Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or No-	14	4. Race - Amei	rican Indian,	_
Examine	ਠ∣		ied 2 Married 4 Divorced	Armed Forces? 1 XXYes 2 If Yes, Give Year or Dates.] No		f Yes, specify Cub. I ☐ Yes 2 🛣 No		o Rican, etc.)	i	Black, White pecify:		
edica .		(Spe	15. Decedent's E ecify only highest gr			(Give		during most of wo	rking	16b. Kind	d of Business	Industry	
Pe ₩	Completed	Elementary/Sec	onday (0-12)	College (1-4 or	5+)		O NOT use retired,) ling Mana	gement	Libi	rarv of	Congres	S
ent, t	ωŀ	17. Father's Name (First, Middle, Last)			onici	OI BUILD	T -	me (First, Middle,				
i i e	의	John Gar	vey					Monica	Enright				
numa	Ī	19a. Informant's Na	ame/Relationship (7	Type, Print)		19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Numbe	er, City or To	own, State, Zip	Code)	
er tra		Karen Ga		fe		1182	Nancy La	ne Crow	nsville	MD 2	21032		
or of		20a. Method of Disp		Removal from State		Place of Dispo emetery, crer	sition (Name of natory or other pla	ce)	Date	20c. Loc	ation - City or	Town, State	
ğ d			5 Other (Speci					Fields 12					
any in		21. Signature of Fu	neral Service bicen	see				ess of Facility Ha Dlis Rd.					
cian/		23a. Part 1. Enter the shock, or head Immediate Cause (disease or condition resulting in death)	rt failure. List only o Final	plications that cause one cause on each lin	e. KEI	HIA	er the mode of dyir	ng, such as cardiad	or respiratory ar	rest,		Approximate Interval Between Onset and Death	
ner	Lec	Sequentially list co	nmediate	b. Due to (or as	a consequ	uence of):							
urial-transit	Examiner	cause. Enter Unde Cause (Disease or that initiated event resulting in death)	iinjury s	c. Due to (or as	a consequ	uence of):							
physicia the bur	edical			l d									
ed by the artending physician detached for use as the buria		IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 🗌 Feta at time of c	al death 3	Ectopic pregnan Other (specify)	су		23	3d. Date of del Month	livery Day Year	
should be deta	d by Pi	Part II. Other signif	ficant conditions of	contributing to death	but not res	ulting in the u	inderlying cause g	iven in Part I.				the cause of death?	٧n
page 2 shou	ompiete				_					psy ormed?	prior to death?	topsy findings available	Э
ceruncate nas rector, page 2		25. Was case referr	ed to medical	_			26. F	Place of Death (Che	ck only one)	2 No	1 ⊔ Yes	2 🗆 No	
ral direct	<u>n</u> o	examiner?	No	Hospital: 1 Inpat	ient 2 🗆	ER/Outpatier	nt 3 🗆 DOA Oth	ner: 4 Nursing I	Home 5 Resid	dence 6	Other (Spec	ify)	
nera	сеппсате:	27. Manner of Deat 1 Natural 2 Accident	5 Pending Investigatio		ury ay, Yea <i>r)</i>	28b. Time of injury	wor	ry at	28d. Describe I				
ed in by the		3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could not be determined				eet, factory, office		28f. Location (S City or Tov		Number or Rui	ral Route Number,	
To the Funeral Director: Af completed filled in by the fu	Medical	(Check 2	Medical Exam	sician: To the best on tiner: On the basis of se Practioner: To the	examination	and/or invest	tigation, in my opini	ion, death occurred	at the time, date a	and place, a	and due to the d	cause(s) and manner sta	ited.
. X ~		29b. Signature and	title of certifier	N C	9/12		29c. Licens	Renumber 3 103		29d. Date	signed (Month	Day, Year)	
9 0 11/2		JENEVI	ERE L	completed cause of CAHTFOC		23a) (Type, F	(45 D	EFENSE	Hwy,	ANN	MPOLI	5,M.D.214	0
State Registrar		31. Date filed (Mont	h, Day, Year) DEC 2 8 2	32. Registr	ar's Signat	ture	rekel						

Amend #16					i n Black Ir yland / Depa			•		.egible.	
			For State Registrar	1010 01 11701		tificate of I			Reg. No.	201	0 42668
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath		3. Time of Death
	ysicia Medic		Roslyn A. Gal	1oway_				Month Decemb	er 1	7 201	0 4:10 p ^M
Ex	kamin	er	4a. Facility Name (if not institution, give street	and number)		4b. City, Town, o	r Location of Dea	ath	4c. Co	unty of Deat	h
- September 1			2047 Gate Drive 5. Social Security Number 6. Sex	7 Age (li	n yrs. last birthday)	Annapol If Under 1 Year	Lis If Under 24 Hr	s. 8. Date of Birt		ne Ar	unde1 hplace (State or Foreign
	neral ector		214-82-5287 I □ M		Yrs.	Months Days	Hours Mir		1962	2 Mar	yland
- AC	Ú		Usual Residence of Decedent	1				1107 20	1302	J III A L	
nyland	ied a	Director	10a. State 10b. County		Dc. City, Town or Lo						10d. Inside City Limits 1
he Ma or 28	notii	Dire	Maryland Anne Aru: 10e. Street and Number	ndel	Annapoli	10f. Zip Code	-		10a. Citizer	n of What Co	
with t	ust be	Funeral	2047 Gate Drive			2140	ĺ			USA	·····
death	ler m		11. Marital Status 12. \	Vas Decedent Ever	r in U.S. 13. \			Specify Yes or No- rto Rican, etc.)	14.	Race - Ame	
36 after of	kamir	l by	1- Never Married 2 Married	☐ Yes 2 ĀNo f Yes, Give		☐ Yes 2X No		rio riodii, etc.)	Spe	Black, White ec <i>ify:</i> B1	
21215-0036 within 72 hours after gjenen "natural", o	cal E	Completed	15. Decedent's Educati	ear or Dates.	16a Decer	lent's Usual Occup	ation			•	
215 n 72 h	Medi	dm	(Specify only highest grade co		(Give	kind of work done of NOT use retired)	during most of wo		Unite	d-Ce	edral Palsy
21; I withi	t, the		12th	0		Care	giver			Cer	chal Palsy
and e filec et al H	even	To Be	17. Father's Name (First, Middle, Last)	D. T.C.			1	ame (First, Middle, 1 Le Porte		name)	
ire, Maryland 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show	matic		Joseph Gallow 19a. Informant's Name/Relationship (Type, P		405 14.75	- 4 1 1 /01 - 4					
Ma 12 sho 14th an	r trau		Darlene Meade (Si			_ ,		Rural Route Number			
Ore, le 1 and t of Hea If item	othe		20a. Method of Disposition	·	20b. Place of Dispo	sition (Name of		nnapoli Date		tion - City or	
imor Page 1 nent of ant: If it	ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Reme 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	Metro C	natory or other plac Cremato:		2-21-10	Ba:	ltimo	re, Md.
Baltimore, permit. Page 1 and Department of Hee Important: If item	any inj once.	1	21. Signature of Funeral Service Licensee		-	. Name and Addre	ss of Facility	na Mort	112 611	T) 7	
— 40 -	10 D		Larry 12, Reen	MO0483		21 West	St. A	ns MOrt	S, Mo	21	
1000			23a. Part 1. Entey the disease, or complication shock, or heart failure. List only one call Immediate Cause (Final	use on each line.	e death. Do not ente	er the mode of dyin	ig, such as cardia	ac or respiratory arr	est,		Approximate Interval Between Onset and Death
Med	dical		disease or condition resulting in death)	HRRhu Due to (or as a co	sequence of:						
Exam	niner			Hyper	tensive	Chrd	ionyos	southy			
	±	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	onsequence of):		1-1				
executed an and	rial-transit	Examiner	Cause (Disease or iinjury that initiated events c resulting in death) Last	Due to (or as a	onsequence of):	M					
	burial	_		Due to for as a et	onsequence oi).						
Box 68760 death certificate b	for use as the bu	Physician/Medica	d								
k 68 certif ending	nse s	an/N	23b. Was decedent pregnant	yes, outcome of p	oregnancy Fetal death 3	Ectopic pregnant	CV.		23d	I. Date of deli	ivery
Boy death	ed for	sici	1 Ves 2 No	Pregnant at tin		Other (specify)				Month	Day Year
P.O. that the need by the	letach	Phy	Part II. Other significant conditions contribu	iting to death but r	not resulting in the u	nderlyina cause ai	ven in Part I.	23e Did to	hacco use (contribute to	the cause of death?
S, P ires th signe	d be c	d by		-	_	, 0 0				_	obably 4 🗆 Unknown
ord requi	shoul	lete	temodisys	omat D	ISAAT A			24a. Was a			opsy findings available
Sec he law te has	age 2	Completed	OU-COUCESIL O	COOC - 3	1 south				rmed? 2 No	death?	completion of cause of
cal Fian: Tian: T	ctor, p		25. Was case referred to medical examiner?			26. PI	ace of Death (Ch		2 L s NO	T L les	2 🗀 140
Division of Vital Records, all or Attending Physician: The law requires ster cleath.	al dire	၉	1 Yes 2 No	1 Inpatient	2 ER/Outpatien	t 3 🗆 DOA Oth	er: 4 🗌 Nursing	Home 5 Resid	ence 6 🗆	Other (Speci	fy)
n of ding F After i	funer	Certificate:	1 Natural 5 Pending	8a. Date of injury (Month, Day, Ye	ear) 28b. Time of injury	28c. Injur work M 1 🗆		28d. Describe ho	ow injury oc	curred	
ivision or Attendi after death Director: A	by the	rtifi	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	Be. Place of Injury -	At home, farm, stre		ies Z 🗆 No	28f. Location (Si	tre e t and Nu	ımber or Run	al Route Number,
Divi	ni be		4 - Hornicide determined	building, etc. (S	pecify)			City or Town			
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici	completed filled in by the funeral director, page 2 should be detached for	Medical	29a. Certifier 1 Certifying Physician: (Check 2 Medical Examiner: C	To the best of my	knowledge, death o	ccured at the time	, date and place,	and due to the cau	use(s) and m	anner as sta	ted.
thin 2.	тре		only one) 3 Certifying Nurse Pra 29b. Signature and title of certifier	ctioner: To the bes	t of my knowledge, c	eath occurred at th	e time, date and p	lace, and due to the	e cause(s) an	d manner as	stated.
			Signature and the or certifier	0 M 1 = 4/	\m	29c. License	タスル	<i>i</i> '	zed. Date si عد	gned (Month	Lay, rear)
PA	/		30. Name and address of person who comple	eted cause of death	ı (Item 23a) (Type. P	rint)	3 31		.~.	000	
Α.	5		JEORGE SAMAN	DEMO	116 k	je Fens	- Wigi	merund	Awn	opulis	12010 5,1MD 21401
Re	Stat gistra	.0	31. Date filed (Month, Day, Year) DEC 2 7 2010	32. Registrar's	Signature .	arke					

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			For State Registrar		aryland	•	tificat			nvientai ny	Reg. N			
	Physicia Media		1. Decedent's Name (First, Middle, Le	Cox	DB	K-RIS				2. Date of De Month	10	Day Yea	0	3. Time of Death
2 3	Examir	ner	4a. Facility Name (if not institution, giver Brooke Grove Number 1)		Rehab	•			r Location of Deatl Spring	1	4	lc. County of De Montgo		у
X .	Funeral Director			Sex 1 □ M 2 🙀 F	e (In yrs. las 92	st birthday) Yrs.	If Unde Months	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth 18 ^{Year} ,	^{9. 1} 1918 F	Birthplac Bountry) Tan	ce (State or Foreign
	and show	ъ	Usual Residence of Decedent 10a. State 10b. County	-	10c. City,	Town or Lo	cation						10d.	. Inside City Limits
	Maryle 28a-1	Director	Maryland Montgo	nery	Sar	ndy Sp								1 🗌 Yes 2 💢 No
	with the	Funeral [10e. Street and Number 18100 Slade School	ol Road				ip Code 2086	0		10g. (Citizen of What USA	Country	?
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	\$	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		1	f Yes, spe	ecify Cuba	ispanic Origin? (Span, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	-	14. Race - Ar Black, Wl Specify: [hite, etc.	
15-0	72 hour "natu ledical	Completed	15. Decedent's (Specify only highest g			16a. Deced		ork done o	ation during most of wor	king	16b.	Kind of Busines	ss Indus	try
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Maryland	d be filed Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) Jules Grillon						18. Mother's Nar Fanny B		, Maide	n Surname)		
Man	12 shoul		19a. Informant's Name/Relationship (Daniel Goldberg-						and Number or Ru rooke Fa					
Baltimore,	age 1 and ent of Hea nt: If item ry or othe		20a. Method of Disposition 1 X Burial 2 Cremation 3 [4 Donation 5 Other (Spec	Removal from State	ce	ace of Dispo metery, cren	sition (Na	me of		Date	20c.	Location - City	or Town	
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. Box 68760	the Hospital or Attending Physician: The law requires that the death certificate be executed that 4 hours after death. That A hours after death. The Huneral Director, thet this certificate has been signed by the attending physician and the Funeral Director, page 2 should be detached for use as the burial-transity and the funeral director, page 2 should be detached for use as the burial-transity.	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal	death 3	Ectopic Other (s		Sy			23d. Date of o	delivery Da	y Year
ds, P.O.	luires that the dea on signed by the a uld be detached f		Part II. Other significant conditions DEMENTIA,	contributing to death to	C-SS	Iting in the u	nderlying	cause giv	ven in Part I. RTCNS)			use contribute		ause of death?
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tal	sician; The la certificate ha irector, page ?	Be	25. Was case referred to medical examiner?	Hospital:				26. Pl	ace of Death (Che	ck only one)				
of Vi	g Physical chils controlled the direction of the directio	e: 70	1 Yes 2 No 27. Manner of Death	1 Inpati 28a. Date of inju (Month, Da	iry 2	R/Outpatien 28b. Time of injury		28c. Injur	y at	ome 5 Resi			ecify)	<u>.</u>
Division	To the Hospital or Attending lwithin 24 hours after death. To the Funeral Director: After completed filled in by the funer	Certificate:	1	on 280 Place of Ini	ury - At hom		M eet, factor		Yes 2 No	28f. Location (and Number or I	 Rural Ro	ute Number,
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	the Ho hin 24 h the Fur	Medical	(Check 2 ☐ Medical Examonly one) 3 ☐ Certifying Nu	niner: On the basis of e rse Practioner: To the	xamination a	and/or invest	igation, in leath occu	my opinio urred at the	on, death occurred e time, date and pla	at the time, date	and place ne cause	ce, and due to the (s) and manner	as stated	d
	Not of		29b. Signature and title of certifier	Dode	illn.	42	29	c. License	o 5763	0	29d. D	Date signed (Mo. $Q - I $	nth, Day	2610
			30. Name and address of person who	completed cause of d	eath (Item 2	23a) (Type, P	rint)		Chill	2 0	0-		12	212 2
	Sta	te	31. Date filed (Month Day Year)	32. Registr	ar's Signatu	S/C	<u> 20</u>	91	SILVE	K X	PRI	NG, 1	11)	20902
	Registr		OEC 2 0 2	UIU Pene	un.	B. A	ark							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ n 809 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birt 9. Birthplace (State or Foreign 1 M 2 F Months Days Min. 7 M21th 93950 Director 217-58-1457 60 Maryland Yrs Usual Residence of Decedent show . Page 1 and 2 should be filed within 72 hours after death with the Maryland iment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1623 Harmony Acres Lane 21409 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Graham Virginia Tull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 23854 Brant Circle, Lewes, DE 19958 Phyllis Fluharty - Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State 1 😾 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Bridgeville Cemetery! 12/23/2010 Bridgeville, DE Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home Myclint Woba 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ NFLAMMATURO CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Live Birth 2 Live and Death Day Month Year signed by the a d be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signal Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s performed' certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: ြု 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending iniury 1 Yes 2 No by the 1 Accident Investigation 24 hours after deal Funeral Director: Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the past of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number am 21438

State Registrar 30. Name and address of person who

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31. Date filed (Mor.

ANNAFOLISMDZIYUI

completed cause of death (Item 23a) (Type, Print)

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6:35P Dec. 2010 Marian LeVerne Glotfelty /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Garrett Garrett Co. Memorial Hospital Oakland If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Months Days Hours 1 □ M 2 🔽 F Director 8/22/1927 Ohio 278-22-4929 83 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Director McHenry Garrett 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21541 101 Bumble Bee Road 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐Yes 2X No 1 Never Married 2 Married Maryland 21215-0036 Specify: 2 White 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Ski Resort Food Service 12 other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Miller Flossie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health 63 Bumble Bee RD., McHenry, MD 21541 James Glotfelty/ Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Deep Creek Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) = 5 permit. Page Department of Important: If any Injury or once. st Cemetery 12/28/10 | Oakland, Maryland 22. Name and Address of Facility Newman Funeral Homes P.A. 21. Signature of Funeral Service Licensee Mallin 179 Miller St., Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) week **Physician** /Medical consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day 5 Other (specify) 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. ģ 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐No 1 ☐ Yes 2 25. Was case referred to medical 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Suppatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 28c. Injury at Work? 27. Manner of Deat Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Division 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To the Funeral Director:
completely filled in by the f 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) and title of certifie 29b. Signatur rson who completed cause of death (Item 23a) (Type, Print) garrett highway oakland, ud 21550 sermo

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 15, 2010 **Physician** December 8:30 Рм <u>Lawrence Dale</u> Groer /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany Frostburg Village Nursing Home Frostburg 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug • 5, 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 X M 2 □ F 85 Aug. Director <u>219-14-5286</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Expriner. "ust, be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 No **Funeral Director** Frostburg Allegany MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21532 16823 Porter Rd., NW 12. Was Decedent Ever in U.S. Armed Forces? 1 Types 2 □ No If Yes, Give Year or Dates: WW2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify: Specify: þ White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Lee ည Joseph L. Groer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16823 Porter Rd. NW, Frostburg, MD 21532 Emma M. Groer/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Country Side Crematory Dec. 18, 2010 Davidsville, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Shock, or leart failure. List only one cause on each line.

Immediate C1 is (Final disease or condition) Approximate Interval Between Onset and Death Immediate C+ se (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

8

Harjit Sidhu, 925 Bishop Walsh Rd., Cumberland, MD 31. Date filed (Month, Day, Year) | 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEC 2 0 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

			For State Registrar	State of M	1arylan		artment of tificate of		Mental Hy	60	10	42673
	Physici	an/	1. Decedent's Name (First, Middle	,,	-				2. Date of D			3. Time of Death
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71.00	Exami	ner	4a. Facility Name (if not institution Bradford Oaks		ie		4b. City, Town, o	or Location of Dea	ath		nty of Death ce Geo	rana
	Funeral		5. Social Security Number	16 Say 7 A		ast birthday)	If Under 1 Year	If Under 24 Hr		irth	9. Birthi	place (State or Foreign
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	and show	5	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Loc	ation				1	10d. Inside City Limits
	Maryl 28a-f otifiec	Director		ce Georges	Mi	tchell	ville					1 🗆 Yes 2 🔀 No
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	ems 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S	13 W	2072 as Decedent of F		Specify Voe or No	USA		
900	e filed within 72 hours after death with the Maryland Ital Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by F	1 ☐ Never Married 2 ☐ Mar 3 ☒ Widowed 4 ☐ Divorced	Armed Forces?	l No	"	Yes, specify Cub.	an, Mexican, Pue	rto Rican, etc.)	ВІ	ace - Americ ack, White, o fy: Blac	etc.
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ylaı	uld be fi Mental narked natic ev	ပြ	Henry White					Delphi	a Davis			
Mar	12 should be file lith and Mental I 27 is marked o r traumatic eve		19a. Informant's Name/Relations			1	g Address (Street					Code)
ē,	f Healt f Healt item 2		George Pasteur, 20a. Method of Disposition		20b. P		Willis S ition (Name of	treet, W	Vestminst Date	20c. Location		Ct-t-
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be it Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		1 Burial 2 Cremation 4 Donation 5 Other (S 21. Signature) Funeral Sentice L	Specify)	Flo	ral Hi	atory or other place 11 Cem.)1-2011	Danvil:	le, VA	
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احد	Ph sician/ Medical Examiner	jr.	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									Approximate Interval Between Onset and Death
o o	icate be executed physician and sthe burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or initiary that initiated events resulting in death) Last	c. Due to (or as a		<u>, </u>						
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within Part hours after death. The Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 【XNo 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a	2 - Fetal	death 3 🔲	Ectopic pregnanc Other (specify)	гу			ate of delive	ry Day Year
ls, P.O	uires that t signed b Ild be deta	β	Part II. Other significant condition	ns contributing to death b	ut not resu	Iting in the un-	derlying cause giv	ven in Part I.				e cause of death?
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ta	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				ace of Death (Che	ck only one)			
<u> </u>	Physion this carral direction	<u>ان</u>	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatie		R/Outpatient 28b. Time of		er: 4 Nursing F	fome 5 ☐ Resid	dence 6 Oth	ner (Specify)	
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Division	ial or Atter is after dea al Director ed in by th	l Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	not be 280 Place of Inju	ry - At hon . (Specify)	ne, farm, stree			28f. Location (S City or Tow	Street and Numb rn, State)	per or Rural F	Route Number,
	the Hospi nin 24 hou the Funera	Medical	only one) 3 Certifying	Physician: To the best of r kaminer: On the basis of ex Nurse Practioner: To the b	amination a	and/or investig	ation, in my opinio	n, death occurred	at the time, date a	nd place, and du	e to the caus	a a / a \ a a a d a a a a a a a d a d a d d
	with Con		29b. Signature and title of certifier				29c. License	number		29d. Date signe	d (Month, D	ay, Year)
			20. Name and address of a second	the complete to	- al- 01	20-1/7	1745	3622		Decemb	er 28,	2010
1	UB5		30. Name and address of person which ACL Signature (Month, Day, Year)	ho completed cause of de	70/	23a) (Type, Prin	29c. License Pys nt)	nd Hla	1 St	warli	z tan	Mp 2014
	Stat Registra	r	31. Date filed (Month, Day, Year)	9 2010 Jenes	a digitatu	A. 1	arke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ne: 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 12 WILLIAM JOHN GOELLER 2010 3:46 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CANDLE LIGHT COVE **EASTON** TALBOT Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 **X** M 2 □ F 215-30-7018 08/22/1933 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1▼Yes 2 No TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 28250 KNAPPS LOT STREET 21601 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No 1953If Yes, Give Year or Dates: 1957 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married 1 ☐Yes 2X No Specify: 3 Widowed 4 Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 DIVISION DIRECTOR FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM BERNARD GOELLER EMMA DVORAK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCES REGINA GOELLER/WIFE 28250 KNAPPS LOT ST., EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 12/22/2010 HURLOCK, MD VETERANS CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. MERCERO 200 SOUTH HARRISON ST., EASTON, MD NOHN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 hermers Oglars Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) LIVING 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventuals must be a search once.

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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attending physician and for use as the burial-trar signed by Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

Division of Vital Records, P.O. Box 68760,

23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☐No

1 ☐ Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Matthe Franks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Multen Fischer

State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

			For State Registrar	State of M	laryland / Depa <i>Cer</i>	artment of H rtificate of D		Mental Hy	giene Reg. No.201	0 42675
	Physicia		Decedent's Name (First, Middle George	Francis	Garlitz			2. Date of De		3. Time of Death
	Medi Examii		4a. Facility Name (if not institution	, give street and number)	Gariitz	4b. City, Town, or			4c. County of	Death
4	Funeral	Н	613 Memoria 5. Social Security Number		je (In yrs. last birthday)	Cumb	erland If Under 24 Hrs	8. Date of Bir	Alleg	
	Director		214-05-5637	1 □ x M 2 □ F	94 Yrs.	Months Days	Hours Min.		29°, 1916	Birthplace (State or Foreign Country) MD
	yland f show ed at	tor	10a. State 10b. County MD A	legany	10c. City, Town or Loc	mberland				10d. Inside City Limits
	he Mar or 28a-	Direc	10e. Street and Number		Cu	10f. Zip Code		Т	10g. Citizen of Wha	1 🗆 Xes 2 🗆 No
	th with the same same same same same same same sam	Funeral Director	613 Memoria				21502			JSA
9800	e filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Š	Narital Status Never Married 2 ☐ Married 3 ☐ Wildowed 4 ☐ Divorced	16.77	X ₁₀ "	Vas Decedent of His f Yes, specify Cubar ☐ Yes 2 ☐ No	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)		American Indian, White, etc. white
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1212	d within lygiene. her tha nt, the I	Be Cor	Elementary/Seconday (0-12)	College (1-4 or 5)T) _	Owner			Food M	1arket
land	be filed fental Hy rked oth tic event	To B	17. Father's Name (First, Middle, L Harvey H. (,				me <i>(First, Middl</i> e, Vora (Drak	Maiden Sumame) (e) Garlitz	
, Maryland 21215-0036	id 2 should be fil eaith and Mental n 27 is marked er traumatic ev		19a. Informant's Name/Relationsh Anne Uddo	ip (Type, Print)	nughter 22	g Address (Street a 211 Killde	nd Number or Ru er St.	ral Route Numbe NE	r, City or Town, State	e, Zip Code) 70122
Baltimore,	permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 ☐ Removal from State pecify)	20b. Place of Dispos cemetery, crem SS Peter 8	sition (Name of natory or other place & Paul Ceme	etery	Date 12/30/20	20c. Location - City 10 Cumb	•
Balt	permit. Depart Import any inj		21. Signature of Funeral Service L	icensee	22.	Name and dares			rland, MD 215	502
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	cate be executed physician and the burial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	a consequence of):	·				<u> </u>
260	ate be e	edical	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	d						
Division of Vital Records, P.O. Box 687	ith certific ittending or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 1 Pregnant at 9 Unknown	2 Fetal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year
P.O.	ires that the dea signed by the a Id be detached f	by Ph	Part II. Other significant condition		ut not resulting in the un	nderlying cause give	n in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
rds,	v requires been sig should b	eted	SPINAL ST	<u> </u>				1 🗆 \	/es 2 □ No 3 □	Probably 4 Unknown
Reco	sician: The law r certificate has b irector, page 2 sl	Completed		FM11 2				1 ☐ Yes	sy prior med? death	e autopsy findings available to completion of cause of h? Yes 2 \(\sumbed{\text{No}}\)
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on of	anding Ph ath. rr. After th ne funeral	Certificate:	27. Manner of Death 1	28a. Date of injury (Month, Day,	y 28b. Time of	28c. Injury a work?			ow injury occurred	Jecny)
Divisi	ital or Atterns after de al Directo		3 Suicide 6 Could n 4 Homicide determin		ry - At home, farm, stree . <i>(Specify)</i>	et, factory, office		28f. Location (Si City or Town		Rural Route Number,
	he Hosp in 24 hou he Funel ipleted fil	Medical	(Check 2 Medical Ex	Physician: To the best of n caminer: On the basis of ex Nurse Practioner: To the b	amination and/or investig	ration in my opinion	death accurred	it the time date ar	ad place and due to the	he course(s) and manner stated
	No. To		29b. Signature and title of certifier	<i>)</i>		29c. License r	number	2	29d. Date signed (Mo	onth, Day, Year)
		-	30. Name and address of person w	ho completed cause of de	eath (Item 23a) (Type, Pri		054	1.	Lac 28	2410
	Stat		GREGG C DON	ALDSON 918 32. Registrar	'e Signaturo		BERLA	am Ou	21502	
	State Registra			4 2011	end d.	backer				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item II per inf/spouse 6915 5/9/II dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HARNEY Month ENNETH Medical 2 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mandrin Chesapeake Hospice House Harwood Anne Arundel Social Security Number 7. Age (In vrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 341-12-8318 88 Hours 2/6/1922 Director Illinois Usual Residence of Decedent or 28a-f show 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location Director 10d. Inside City Limits Maryland Prince George's Bowie 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12605 Memory Lane 20715 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates, 1942-62 1 Tes 2 No Specify than "natural", 3 Widowed 4 Diverced Completed Specify: White permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 vears Tech Sergeant U.S. Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Hadley A. Harney Mamie Haxel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele D. Harney/ Daughter 12605 Memory Lane, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)

21. Signation 15 of the policy of the control of th Kalas Crematory 12-19-2010 Edgewater, MD 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) a Amous Medical Jul to (or as a consequence of): Examiner Sequentially list conditions, Examine Date to (or as a nonsequence of if any leading to immediately cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) To the Funeral Director. After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant
Unknown Pregnant at time of death Day Year 1 Yes 2 g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably → ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autons 1 Yes 2 No Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work? after death Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of **#**ert 29c, License number 29d. Date signed (Month, Day, Year) embre 16 WU son who combleted cause of death (Item 23a) (Type, Print, Name and address of pe NNAPOUL 441 31. Date filed (Month, Day, Year) State DEC 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vivian Elaine Hardesty 24, 12:03PM Dec. 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Dennett Road Manor Oakland Garrett If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 1 □ M 2 🔀 F Months /19/1935 217-30-1549 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Garrett Deer Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23 Hubbard Road 21550 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2XINo Specify 3 ₩ Widowed 4 Divorced Specify. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Clement Tasker Olin Marie Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Tusing/ Daughter 405 N. <u>St., Mt. Lake Park, MD 21550</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moon Cemetery 12/29/10 Deer Park, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes P.A. St., Oakland, MD 21550 Matthe 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NON alcoho disease or condition resulting in death) Due to (or as a consequence of): Years Sequentially list conditions

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral Director

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Maritral Examinating the rotified at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical Exam Be Completed Certification: To

Division of Vital Records, P.O. Box 68760,

Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):	
sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	23d. Date of delivery Month Day Year
Completed by Physician/Medical	Part II. Other significant conditions of Peripheral VASCALINE (A	contributing to death but not resulting in the underlying cause given in Part I. What divease; Granic feeding of Scuse	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? death? 1 Yes 2 No 1 Yes 2 No
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0	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)		
ation:	27. Manner of Death 11 valuation 15 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day, Year) September 28b. Time of Injury 28c. Injury at Work? Month Mo	28d. Describe how injury occurred
Certification: T	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
5	20h Signature and title of contifier	()	

State Registrar

29b. Signatule and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Florence Mary Harrison December 2:20 P M Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b City Town or Location of Death 4c. County of Death 2800 McDuff Dr. Chesapeake Beach Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**XX**F Hours Director Washington, DC 577-24-6729 87 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 4 1 1 Yes 2XX No Calvert. Chesapeake Beach 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2800 McDuff Dr. 11. Marital Status 12. Was Decedent Ever in U.S. Was Deceue.... Armed Forces? → Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 3 X Widowed 4 □ Divorced 1 Yes 2 No Specify Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) 12 Secretary US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward H. Hamilton Stella E. Tucker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin Harrison (Son) 2800 McDuff Dr. Chesapeake Beach, MD 20732 20a. Method of Disposition

120 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland Washington National Cemetery 2010 M/1555 21. Signature of Funeral Service Licer 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Se Ph sician/ 0315 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events Examin or Attending Physician: The law requires that the death certificate be executed CEVELONDUGS CULAN use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Dav Year 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? certificate 1 Yes 2 No Yes 2. NO Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify ျင 1 ☐ Yes 2 ☑ No After this 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 Yes Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) December 22,2010 Me 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month

Dr, Tardio, M.D.110 Hospital Road #310, Prince Frederick, MD 20678

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month December 26, 2010 Physician 8:25 p M Walter James Harris /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cheverly Prince George Gladys Spellman Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1X M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 234-52-2216 Director March 12, 1934 West Virginia Usual Residence of Decedent 10d, Inside City Limits 10a State 10h County 10c, City, Town or Location other traumatic event, the Medical Exemples must be notified at 1 ☐ Yes 2X No Director Maryland Waldorf Charles 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. "nstural", or itsms 23a 20603 10804 United Court by Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 □ No If Yes, Give Korea Year or Dales: Vietnam 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3

Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) s 1 end 2 should be filed within if Health and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Car Dealership 12 Auto Parts Delivery 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Walter N. Harris Emma Loving 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6398 Hardbargain Circle, Indian Head, Md. 20640 Tiffany Bolden Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec. 29, 2010 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
important: if ites 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metropolitan Funeral Service 4 □Donation 5 □Other (Specify) Alexandria, Virginia 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral Service Licenses M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Septicemia /Medical Due to (or as a consequence of): Examiner b. Gram Positive Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 4 Pregnant at time of death 9 Unknown 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Anemia, Encephalitis 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Diabetes Mellitus 24a. Was an autopsy 1 Yes 2 X No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Magner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified Dec. 27, 2010 Doo26024 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lester Miles, M.D., 1160 Varnum St., N.E., Washington D.C. 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 12680 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month -22-2010 Samuel Hall 10:00p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2006 Wingate Ct.Unit Waldorf Charles Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Month, Day, Year) - 22 - 1 9 4 5 1 🔀 M 2 🗆 F Months Hours Min Days Washington DC Director Yrs 65 79-54-7023 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No <u>Maryland</u> Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2006 Wingate Ct Unit 20602 USA should be filed within 72 hours after death and Mental Hygiene. is marked other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. Completed 3 Widowed 4X Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Trucking <u>Driver</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Thomas Jefferson Hall Rosie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Cassandra Winder/Daughter 10375 Cassidy Ct.Waldorf MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Mem.Cem 112/30/10 Waldorf, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Adams Funeral Home Pa, Aquasco MD 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, Lacing to immedicause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' 124 hours after death. e Funeral Director: After this certificate 1 Yes 2 No Yes 2 1 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 ☑ No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one the re and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person w completed cause of death (Item 23a) (Type, Print) 13605 Cot Westwood Samue Brandywine 20613 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Benjamin Jerman Jr. December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Anne Arundel Medical Center Arunde1 Anne 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Country) Ann, Maryland 1 X M 2 □ F Min 03/04/1941 212-42-4300 69 Director Usual Residence of Decedent 23a or 28a-f show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Gambrills 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 766 Maryland Route 3 N 21054 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2**X** No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Auto Technician Shop Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Benjamin Jerman Sr. Lucille Eisele permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Jerman 766 Maryland Route 3 N Gambrills, MD 21054 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baldwin Memorial 12/28/2010 Millersville, MD Signature of Funday Service Lice 22. Name and Address of Facility Hardesty Funeral Home P.A. Gambrills, MD 21054 ale 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) nding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 use as f yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery atter in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be der þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 2 🗌 Ne 1 🗖 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natura! 5 Pending death. 1 Yes 2 No Accident Investigation after death the 3 Suicide 4 Homicide 6 Could not be n 24 hours after de e Funeral Directo bleted filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hours To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nyrse Practioner, To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 3 🗌 only one) 29b. Signature and itle of License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EC 2 8 2010 31. Date filed (Month State Registrar

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o' the	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but		only one) 3 Certifying i	vurse Pra	actioner:	to trie best of	rny knowle	uge, dea	ath occurre	ed at the	number	e and place	, and due to th	ne cause(s) and ma	nner as stat	ed.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Degedent's Name (First, Middle, Last)
DARBARA 2 Date of Death 3. Time of Death Physician/ Month Year /U ZUDORA CICSUN 1340 Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗸 F Months Days Hours Min 224-48-9510 72 Yrs **VIRĞINIA** MARCH **Director** 1938 Usual Residence of Decedent or 28a-f show notified at 10b. County be filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No MD CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 122 SHERMAN ROAD 20602 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc. 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: BLACK "natural" 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER HOMEMAKER 12 permit. Page 1 and 2 should be filed wil Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ARSENIA STYLES PEARLINE E. ALLEN STYLES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 SHERMAN ROAD. WALDORF. MARYLAND 20602 EDWARD JACKSON/HUSBAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 1/5/2011 4 ☐ Donation 5 ☐ Other (Specify) MD VETERANS CEMETERY CHELTENHAM. MARYLAND 21 Toy turn of Fund Service Lion THORNTON FUNERAL 3439 LIVINGSTON LHOME, PA ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNTON JUNION MO0583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. terval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impory that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' Yes 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h Yes ☐ Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier hn 23 2010 Name and address of person who completed cause of death (Item 23a) (Type, Pri 708 6 Ca. 31. Date filed (Month, Day, Year) Registrar's Signature State 28 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Joan A. Jenkins Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Western Maryland Regional Medical Center Allegany Cumberland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Funeral (Month, Pay, Year) April 26, 1933 Days Hours Min. 1 - M 2 X F West Virginia 217-28-9561 Director Usual Residence of Decedent or 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland Examiner must be notified at Director Maryland Allegany Frostburg 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 87 Victoria Lane items 23a Funeral 21532-U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 □ Divorced White Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. .ant: If item 27 is marked other than 2^{College (1-4 or 5+)} Elementary/Seconday (0-12) Nursing Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elonza Hare Evelyn Shanholtz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 21532-**Bobby Poland** Maryland Son 87 Victoria Lane Frostburg 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date emetery, crematory or other place)
Frostburg Memorial Park 1 Burial 2 Cremation 3 Removal from State Maryland December 30, 2016 Frostburg 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications the Leaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eumanva Physician/ deys Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Urinary Track intection 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, Be examiner? Hospital Other: 1 Tes 2 🗓 မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at ë 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After work? 1 Natural 5 Pending Certificat Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: Tothe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) leath (Item 23a) (Type, Print) noss

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010

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		•	For State Registrar	Oldio ol Mic	()	Certificate of	Death	1	Reg. No.			
	Disconinia	/	1. Decedent's Name (First, Middle	le, Last)				2. Date of Dea		Voor	3. Time of Death	
	Physicia Medi		Michael Walte					Decembe	r 23,20	010°	1633 м	
	Examir	ner	4a. Facility Name (if not institution				r Location of Death			y of Death		
-	F		422 State Stre 5, Social Security Number		(In yrs. last birth	Annapo		☐ 8. Date of Birt		Arun	deL	
	Funeral Director		220-56-9432	1 X M 2 🗆 F		rs. Months Days	Hours Min.	057017			ngton DC	
	nd how at	7	Usual Residence of Decedent 10a. State 10b. County	/	10c. City, Town	or Location				10	Od. Inside City Limits	
	faryla 8a-f s tified	ect	MD Anne	Arunde1	Annap	olis					1 Yes 2 No	
	vith the N 23a or 2 st be no	Funeral Director	10e. Street and Number 422 State Str	eet		10f. Zip Code 214	÷03		10g. Citizen of	What Count	try?	
	eath v	Į,	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-		ce - America		
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Menta Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by I	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If Von Cive	No	1 ☐ Yes 2 🌠 No		Rican, etc.)	Specif	ack, White, e y: Whi		
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Maryland 21215-0036	12 should alth and Math and Market 27 is ma		Walter Paul Kuzmuk Faye Griff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route							te Number, City or Town, State, Zip Code)		
Baftimore,	age 1 and ant of Hea it: If item y or othe		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (3 Removal from State	cemetery	Disposition (Name of crematory or other pla	´ ;	Date	20c. Location			
薰	nit. Partme		21. Signature of Foneral Service		Atlant	ic Cremator 22. Name and Addre		27/2010				
m	Departi Impol any ir		Voat A	011		22. Name and Address Hardesty 1	Funeral H	ome P.A.	Annapol	dis,MD	21401	
	Physician/ Medical		23a. Part 1. Enter the Lease, of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each line.		elevotio	-			ie	Approximate Interval Between Onset and Death	
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. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 Pregnant at 9 Unknown	2 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify) _	су			ate of delive onth	ry Day Year	
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on of	nding Ph ath. r: After th e funeral	icate:	27. Manner of Death 17 Natural 5 Pendi 2 Accident Invest	28a. Date of injur ing igation	y 28b. Tir Year) inj	ury wor		28d. Describe ho	ow injury occur	red		
Division	al or Atte s after de il Directo	Medical Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr			n, street, factory, office		28f. Location (S City or Town		per or Rural I	Route Number,	
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	To th To th comp	5	29b. Signature and title of certifie)epu	ter 29c. Licens			29d. Date signe			
	AR.		30. Name and address of person	who completed cause of de	ath (Item 23a) (Ty	pe, Print)	1-1-	- N	,		2.45	
	Sta		31. Date filed (Month, Day, Year)	8 2010 32. Registra	's Signature	mD.	U 45	TN	regi	CA	×1035	
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Registrar DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1Cusin Physician/ Month ESLEY 024 OM 20/0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Month, Day, Year)
July 29, 197 1 Z M 2 D F Months Days Hours Min 193 12 2680 Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XXNo Maryland Maryland Caroline Preston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6318 Statum Road 21655 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. <u>ک</u> 1 Never Married 2 Married 1 XXYes 2 ☐ No WIII Maryland 21215-0036 1 ☐ Yes 2x No Specify: 3 XWidowed 4 □ Divorced Specify: White Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Dept of Navy Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic eve and Mental မ Mary Sari George Kusin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6318 Statum Road, Preston, MD 21655 Sharon Fortuna (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Kurial 2 Cremation 3 Removal from State Cheltenham, Maryland 4 Donation 5 Other (Specify) Maryland Veterans Cemetery Jan 5, 2010 21. Signature of Funeral Service Licens 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Box (jo in the past 12 months? Month Year Day 1 Yes 2 No ed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? neral Director: After this certificate has been signed filled in by the funeral director, page 2 should be de Completed by 1 Yes 2 No 3 Probably Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 ျှ 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending Natural 5 Pending s after death. 1 Yes Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier racertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. сотрыете To the within 2 only one who completed cause of death (Item 23a) (Type, Print) Name and address of person NB5+ Hwy ANNAPOUS MDZIFOI ICHAR ENTAM 31. Date filed (Month, Day, Year) . Registrar's Signature **DEC 28** ASKAR.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lubozynski Joseph December 2010 11:22 A M Medical 4a. Facility Name (if not institution, give street and number) **E**xaminer 4c. County of Death 7518 Oakmont Drive Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Pennsylvania 1 🕅 M 2 □ F Director 210-14-1082 87 December Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Frederick Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral United States 7518 Oakmont Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 X Married 1 X Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Wildowed 4 Divorced White Completed Year or Dates. WWII 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Commercial Airlines Airline Pilot Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ignatz Lubozynski Amelia Bialek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7518 Oakmont Drive, Frederick, Maryland 21702 Marie Lubozynski / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January 5, cemetery, crematory or other place)
St. John's Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Frederick, Maryland of Funeral Service Lice Reeney and Bastord PA Funeral Home MO1473 Church Street. Frederick. MD 21701 23a. Part 1. Enter the disease shock, or heart failure. r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each, line. Interval Between Onset and Death Immediate Cause (Final Physician/ enna h disease or condition Medical resulting in death) Due to (or as a cons uence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Ves 2 □ No 3 □ Probably 4 □ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? hours after death. Ineral Director: After this certificate ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑No Other: ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 Inpatient 3 Inpa 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1. Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accider
3 Sulcide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral L

State Registrar DHMH 17 Rev 7/2009 29a. Certifier

(Check

31. Date filed (Month)

29b. Signature and title of certifier

OFFA

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pearre

1 🚉 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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300 West Ninth Street, Frederick, Maryland 21701

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** December 9:04 P James Minton 2010 Raymond /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Ft. Washington Hospital Center Ft. Washington If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 1/12/1960 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days **X** M 2 □ F Months Hours 50 Director 262-47-4606 Maryland Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 □Yes 2 🕅 No Director Bryans Road Maryland Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20616 6564 Cornell Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Yes 2 Y If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: ₽ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than ' Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter th and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara Juliana Balough John Lee Minton ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar ant: If item 27 is permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tra 6564 Cornell Road, Bryans Road, MD 20616 <u>Linda Ann Minton/Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Edgewater, MD Kalas Crematory 1/1/2011 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signatur Juneral Service Licensee alus 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 23a.*Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Ulm Sequentially list conditions, Examiner If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 🕱 No 1 □Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1xxYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Watural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deatl To the Funeral Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Medical 📶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3N68061V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 11711 Livingston Rd. Ft. Washington, MD

MD

32. Registrar's Signature

A. Narasimhan

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2/10/2011 JH. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 16 Physician/ Month 2010 December 0833 <u>Ann R. McNeal</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Rockville Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Year) | Dec. 22 1 94 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 421-64-7288 1 □ M 2 🖾 F Months Director 63 Yrs. MO Usual Residence of Decedent 10a. State 10b. County with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f s notified 1 X Yes 2 No Maryland Montgomery Montgomery Village 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with th Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be Funeral 19635 Brassie Place USA 20886 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by 21215-0036 Black If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Elementary/Seconday (0-12) College (1-4 or 5+) Education 12th <u>Program Officer</u> yrs Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ann L. Peoples George L. McNeal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George McNeal (Brother) 2127 Harbor Dr. Annapolis, Md. 21409-5716 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 12/20/10 Baltimore, Md. Metro Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility

Vm Reese & S
821 West St. 21. Signature of Funeral Service Licenses ons Mortuary, PAAAnnapolis, Md. 21401 Wm 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death PLEOMORPHIC Physician/ a HIGH GRADE disease or condition MALIGNANCY Medical resulting in death) Due to (or as a consequence of) Examiner STAGE Securitary liet or different if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed HYPOTENSION that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months.

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year signed by the signed for detached for significant sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Vinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed' 2 No Yes 2 🕨 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one) 29b. Signature-and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOO 67512 DECEMBER 16, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BANGALORE MD 9901 MEDICAL CENTER DRIVE ROCKVILLE MD 20850 31. Date filed (Month Car Year) 2010 32. Registrar's Signature State Back Registrar

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DECEMBER

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 16, December Robert Davies McClure 2010 2:05 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8 Date of Birth 9. Birthplace (State or Foreign Min. 7/17/1935 Months Hours West Virginia Director 232-54-7022 7.5 Usual Residence of Decedent show ral", or items 23a or 28a-f shorex Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland| Anne Arundel 1 Yes 2 No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2709 Yeomans Lantern Court 21401 USA death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 Types 2 No 1953If Yes, Give
Year or Dates. 0 Black, White, etc. 1 Never Married 2 Married þ 72 hours after 3altimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", 3 Widowed 4 Divorced Specify: White Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Computer Software Engineer marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Phyllis E. Davies Robert S. McClure 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra A. McClure/Wife 2709 Yeomans Lantern Court, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory Edgewater, Maryland 12/20/10 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Mull 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ TROKE MASSIVE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Yes been signed by the should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CARDIOMYOPATHY 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 2 certificate has autopsy perform death? Yes completed filled in by the funeral director, æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ ER/Outpatient 3 DOA after death. 1 Inpatient 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours a Funeral L Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the best of my knowledge, death occurred at the mine, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the bast of my knowledge, death commend at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29b. Signature and title of certifie 29c. License number

State Registrar STEPHEN

Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

116 DEFONSE

32. Registrar's Signature

HAMILTON

D41698

400 HANDROUS, MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 2:10 P M December <u>James August Mever</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 1 M 2 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** 10/13/1938 Illinois 72 333-34-6384 Yrs. **Director** Usual Residence of Decedent or 28a-f show e notified at and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Anne Arundel Edgewater 1 Tes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 3 Steuart Lane 21037 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify. Specify: 3 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Teacher High School years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Grace Dale Venis Meyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dora Sue Meyer/ Wife 3 Steuart Lane, Edgewater, Maryland 21037

Maryland 21215-0036

mor	ent of H nt: If its y or of		1 X Burial 2 ☐ Cremation 3 ☐ F	Removal from State cemete	or disposition (ivame or ery, crematory or other pl t Memorial Car	lace)		zidsonvi	lle, Maryland
Baltimor	Department of Popartment of Important: If its any injury or of once.		21. Signature of Tureral Service License		22. Name and Addi	ress of Facility Geo	rge P. Kai	las Fune	ral Home
	nysician/		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only one Immediate Cause (Final	ications that caused the death. Do recause on each ine.		Dala /		ewater,	Approximate Interval Between Onset and Death
	Medical Examiner	Ļ	disease or condition resulting in death) Sequentially list conditions,	Due to (or as a consequence of a A A C	office A	Mest	- /		Mus
patric	nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a consequence	,				
SC Te be exec	ıysician aı ne burial-t		resulting in death) Last	Due to (or as a consequence of	of):				
. Box 68/60	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	h 3 Ectopic pregna 5 Other (specify)		23d. Date of delivery Month Day Year		
ds, P.O.	en signed by	۾ ا	Part II. Other significant conditions cor	ntributing to death but not resulting	in the underlying cause (given in Part I.			the cause of death?
Hecor The law re	cate has be	Completed					24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of s 2
'ITal	certific irector,	Be c	25. Was case referred to medical examiner? 1 Yes 2 Ro	lospital:	_	Place of Death (Check			-
DIVISION OT VITAI RECORDS, lal or Attending Physician: The law requires	ath. r: After this ne funeral d	Certificate: To	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident □ Investigation		Time of 28c. Injury wo		me 5 Residence 28d. Describe how inju		2(17)
DIVISION Affe	s after de al Directo ed in by th		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	9 2	28f. Location (Street a City or Town, Stat		ral Route Number,
he Hospi	in 24 hour he Funer	Medical	(Check 2 Medical Examin	cian: To the best of my knowledge, er On the basis of examination and/o Practioner: Jo the best of my know	or investigation, in my opin	nion, death occurred at	the time, date and place	ce, and due to the	cause(s) and manner stated.
Į.	To t		29b. Signature and tipe of certifier	e/	29c. Licen	35490	29d. D	ate signed (Month	h, Day, Year) 2016
H	-10		30. Name and address of person who co	snick AN	(Type, Print) Alu	nole	Malic	a/ Ce	store
	Stat Registra	te ar	31. Date filed (Month, Pax, Year) UEC 2 0 20	32. Registrar's Signature	park				
DHMH	17 Rev 7/20	009		0010	SINIAI				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Malone 211 5 M Dorothy M. December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Memorial Hospital at Easton lalbot 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🎇 F Days Hours 2 (Man/1 92 Year) Virginia 90 Director 579-12-8394 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland other traumatic event, the Medical Examiner must be notified at Funeral Director 1 ☐ Yes 2 🛣 No Talbot Queen Anne Marvland 10e. Street and Number 10f. Zip Code ö 10g, Citizen of What Country? "natural", or items 23a USA 21657 30093 Pahlmans Wav should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: White 3 😾 Widowed 4 🗆 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be **Maryland** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F ပ္ Cora Leona Taylor Zebedee Oliver Kines and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra 1206 Chrisland Court, Annapolis, MD 21403 Nancy M. Jabin/Daughter 20a. Method of Disposition
1 Å Burial 2 ☐ Cremation 3 ☐ Remova from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 12/21/2010 | Arlington, Virginia Columbia Gardens 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Rome Signature Funeral Service Licenses 2973 Solomons Island Road, Edgewater, MD 21037 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one bause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying burial-transit Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a onsequence of) attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 Fetal death in the past 12 months? Day Month Year Pregnant at time of death Tyes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: မူ 1 🗌 Yes 2 No 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur and title of certifie DXX62626 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ACTEC 31. Date filed (Month 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 2:45 P M Sebastian S. Mignosa Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 12627 Heming Lane Bowie Prince George's Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Jan. 6, Connecticut 044-22-1578 Director Usual Residence of Deceden 28a-f shov 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Hautral", or items 23a or 28a-f sho and It item 27 is marked other than "natural", or items 23a or 28a-f sho uny or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Prince George's Bowie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12627 Heming Lane 20716 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 1952-54 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government FBI Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Salvatore Mignosa Sarina Marino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa L. Mignosa / Spouse 12627 Heming Lane, Bowie, MD 20716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Cemetery 12/23/2010 Bowie, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a. Capt . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ ese bru Medical resulting in death) Due to (or as a consequence of) Examiner Car Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a con attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Consent at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year signed by the a d be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 11:52452 arkin Son's 1 ☐ Yes 2 📶 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 ANO Other: ᅆ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 AResidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Medical 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 5 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sambrill, mo 21057 Charry DEC 2 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December Day Physician/ Charlotte Mary McLean Martin 17-2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Prince George's Lanham If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Year 936 1 □ M 2X F Feb. 24 Louisiana 437-52-3774 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🖁 No MD Prince George's Glenn Dale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 6503 Wood Pointe Dr. 20769 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. "natural", or iter Black, White, etc. þ 1 Never Married 2 Married African 1 ☐ Yes 2 X No Specify: 3 ☐Widowed 4 ☐ Divorced Completed American Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) event, the Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Daniel McLean Hariette Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau-once. Valencia Martin Wallace /daughter 6503 Wood Pointe Dr., Glenn Dale, MD 20769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Stother (Specify) entombment 12/21/2010 Clinton, MD Resurrection Cem. 22. Name and Address of Facility Beall Funeral Home Signature of Funeral Service Licenses 6512 NW Crain Hwy., Bowie, MD 20715 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Brain Tamour Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and s the burial-transit that the death certificate be executed Due to (or as a consequence of): Physician/Medical signed by the attending p be detached for use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Coronary artery orserse 1 Yes 2 No 3 Probably 4 thin nown Completed the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Thrombocy topenia. 24a. Was an autopsy performed? certificate 1 Tes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifics 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title D 42580 12-19-10 Altensive 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLADGUS BURG MD- 20710. Annapolis Suite 4 13 Road 31. Date filed (Month, Day

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 –** For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Marvin Miller Medical la. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany WM Regional Medical Center Cumberland ocial Security Numbe 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours March Day Ye 220-16-6396 1**√2√**M 2 □ F 84 ່ 1926 Maryland Yrs. Director Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Allegany Westernport 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code **21562** 10g. Citizen of What Country? 421 Hammond St, Apt. 211 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No WW 2 "natural", or iterr ledical Examiner r Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify: 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 tal Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Paper Manufacturer unknown Operator Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 2 Leslie Miller Louise Biddle 19a. Informant's Name/Relationship (Type, Print)
Marilyn Rounds/ daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18512 Takoma Drive, Barton, Maryland 21521 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Cumberland Crematory 12/28/2010 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Cumberland Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee 111 Church St, Westernport, Maryland 21562 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Copontre disease or condition Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ned for t in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death the Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performe 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Impatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Antural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifie 1 🖆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) V 21244 12 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print)
Pr. Jesus Tan, 4 Broadway, Frostburg, MD d

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

DEC 28 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Emme 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Tar 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** If Under 1 Year 24 Hrs. 1 M 2 D F Min. 8 Director Usual Residence of Decedent fshow and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shouther traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No dr 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21520 SA 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 2 🗌 No Baltimore, Maryland 21215-0036 Y Yes 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates. 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done (life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) INDUSTRIAL SALES CHINER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Royte Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility nd Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final set and Death Physician/ year s disease or condition Medical resulting in death) Due to (or as a consequence f) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of, Exam the Hospital or Attending Physician; The law requires that the der th certificate be executed and -tran resulting in death) Last Due to (or as a consequence of) ttending physician a or use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Month 2 No ed by the detached 9 Unknown Unknown Division of Vital Records, P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page performed? Yes 2 K No 1 Tes Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital: 2 No 4 Nursing Home 5 Residence 6 Other Specific Other: 1 Yes 은 1 Inpatient 2 ER/Outpatient 3 IDOA After this Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred s after dea... 1 Natural 5 Pending (Month, Day, Year) 1 Tes 2 🗌 No Accident Investigation within 24 hours after de To the Funeral Directo completed filled in by th Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP 31. Date filed (Month, Day, Year) **DEC 28**

Registrar

10-09900 **Ernest Moreland** Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	ا	I- For State Registrar Amend#2perDVR1/10/2010c dobr	içate o	f Death			g. No.	
Physician dical Examine	Ш	1. Decedent & Harris (First, Hindais, 2004)				2. Date of Death Month	Day 2 Year	3. Time of Death 2045 hrs
icai Lxaiiiii		Ernest Moreland 4a. Facility Name (if not institution, give street and number)		4b. City, Town, o	r Location of Deat	December h	4c. County of De	
		Calvert Memorial Hospital		Prince Fred	drick		Calvert	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last to 1. 1 M 2 F 92	birthday) Yrs	Months Day				Birthplace (State or reign Country) Maryland
any	+	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tov	wn or Loca	tion				10d. Inside City Limits
* .*	Director	Maryland Prince George's	Cani	tol Height	S			1 Yes 2 No
vlaryland 28a-f show		10e. Street and Number	остра	10f. Zip Code		10	g. Citizen of What C	ountry?
h the h	ַבֿ	527 Capitol Heights Blvd		20743			United Sta	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene 27 is marked other than "natural", or items 23s or 28s-f sho matic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 XX Yes 2 No 3 XX Widowed 4 Divorced If Yes, Give Year		Yes, specify Cuba	n, Mexican, Puert	Specify Yes or No- o Rican, etc.)	White, etc	
irs afte	ᅀ	l or Dates:	ia. Decede	Yes 2 XX No	specify: ation (Give kind of	work done	Specify: W 16b. Kind of Busine	nite ss/Industry
72 hor	활	Elementary/Secondary (0-12) College (1-4 or 5+)		nost of working life		tired)	Federal G	
5-0036 led within 72 hours afte Hygiene other than "natural", the Medical Examine	Completed	12	Bull	ding Engin		(F) 1 1 1 1 1 - 1 1		overnment ——————
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	ညို ကြ	17. Father's Name (First, Middle, Last) Harry Moreland				e (First, Middle, M Elsroe	naiden Surname)	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the injury or other traumatic event, the Med		,					ber, City or Town, St	
MD and 2 sho ulth and a 27 is		Sheila Gould (Daughter)		1	0	, 1	Heights,MD	
Ore, es l an of Hea L'iter		1 X Burial 2 Cremation 3 Removal from State crem	natory or of			Date	20c. Location - City	
Baltimore, ormit. Pages I ar Department of Her Important: If ite injury or other tr	ļ	4 Donation 5 Other Specify.		Cemetery		· ·	Suitland,	MD Cld Alexandria
Department of the position of		21. Signature of Foreral Service Licensee m 0153)	erry Road,			ле, ше ооо	CIU AIEXAIUI IA
Physician	7	23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.					est, shock, or heart	Approximate Interval Between Onset and
`/Medical ≟xaminer	İ	Immediate Cause (Final disease a Hypertensive Atherosclero	tic Card	iovascular Di	sease Compl	icated by Hip	Fracture	Death
		or condition resulting in death) Due to (or as a consequence of):						
6	틸	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause						
	Examiner	Cisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			_	_		
recuted and and transit		d						
ੂੰ ਫ਼ਿਜ਼ ਦੇ	Medical	UNPENDED AMENDED						
8760, tificate be ng physici as the buri		IF FEMALE: 23b. Was decedent pregnant in the past 12 mostly 2 most	_	etal death 3	Ectopic pregr	ancy	23d. Date of deliver Month	very Day Year
Box 687 e death certific the attending of the use as the	SC 28	4 Pregnant at time of death	-	ther (Specify)				
D, BC trithe de by the	Physician	Part II. Other significant conditions contributing to death but not result	Iting in the	underlying cause	given in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that t is after death. **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detachastification: To Be Completed has been sections.	음					1 Yes	2 ✓ No 3 F	Probably 4 Unknown
w requires w been sign should be	Completed					24a. Was a		autopsy findings available to completion of cause of
he law ate has age 2 s	틹			-		perform		
tal Recision: The certificate ector, page	Be	25. Was case referred to medical examiner?		26.Plac	e of Death (Check	only one)		
Physic al direction	인	1 ✓ Yes 2 No	//Outpatien		Other4 Nurs		Residence 6 0	her:
oding Ph th.: After t e funeral	Certification:	(Month Day Year)	b. Time of 515 hrs		Yes 2 ✓ No	Subject fell	low injury occurred	
risior r Attend er death irector: a by the	ള	2 🗸 Accident Investigation 28e Place of Injury - At home	e, farm, stre	et, factory, office	building, etc.			Rural Route Number, City
Divis		Suicide 6 Could not be determined (Specify) Veteran's Hor	me			or Town, St 29449 Charlott	^{tate)} te Hall Road, Cha	rlotte Hall, MD
		29a. Certifier (Check only Certifying Physician: To be best of my knowledge, of the control of t	death occu	rred at the time, o	ate and place, an	d due to the cause	e(s) and manner as s	stated.
To the Hos within 24 h To the Fur completely	8 L	one) 2 Medical Examiner: On the basis of examination and/o and manner stated. 29b. Signature and atte of certifier	or investiga	29c. Licen		at the time, date a	and place, and due to	
	-	250. Signature and attention certifier		O.C.			December 24,	
OC ME	-	30. Name and address of person who completed cause of death (Item 23a	a)					
2815+1		Mary G. Ripple MD. Deputy Chief Medical Examin		1 Penn Stree	t, Baltimore, I	MD 21201		
Stat	6.0	31. Date filed (Month Day, Year) 32. Registrar's Signature	1	ds/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day}20, 2^{Year}10 December Clark Doyle Mittan 1:25 pM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2316 Valley Oak Court Charles Waldorf 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Nebraska **Funeral** 8. Date of Birth 1 XM 2 □ F Months Days 505 44 5077 Hours Min Jan 19 Year) 939 71 Director Usual Residence of Decedent show 10a. State with the Maryland notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD Charles 1 Yes 2 No Waldorf 10e. Street and Numbe 10f. Zip Code "natural", or items 23a o 10g. Citizen of What Country? Funeral 2316 Valley Oak Court 20601 USA 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

144 Yes 2 No
If Yes, Give ģ 1 Never Married 2 K Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) d 2 should be filed with alth and Mental Hygien 27 is marked other th Physiological Trainer USAF æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Glen Mittan Cora Clark other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Charlotte Mittan/ Wife 2316 Valley Oak Ct.Waldorf, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State MD Veteran Cem. Jan.5,2011 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lice 22. Name and Address of FacilityBriscoe-Tonic Funeral Home 2294 Old Washington Rd.Waldorf,MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Onset and Death Ph sician/ Conce disease or condition Medica resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) executed burial-transit resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day 2 No the be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? this certificate Yes XNo or Attending Physician: filled in by the funeral director. 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 2 No Other: Certificate: To 1 L Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of De 28b. Time of 28c. Injury at work? after death. Director: After 28d. Describe how injury occurred 1. Natural
2 Accident
3 Suicide injury 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier Lactifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi-29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 120

State Registrar 31. Date filed (Month, Day, Year,

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0845 A M James H. Mackley December 24, 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 30 W. Main Street Thurmont Frederick 8. Date of Birth (Month, Day, Year) Jan 3, 1929 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1**XX**M 2 □ F Months Hours Min. 81 Maryland 213-24-9853 Jan Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director Frederick Maryland Frederick TX Yes 2 No 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? ō ural", or items 23a o Funeral 21788 USA 30 W. Main Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc Completed by 1 Never Married 2 Married 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white If Yes, Give Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Business Forms Machine operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ruth Holdcraft Lloyd Mackley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 30 W. Main Street, Thurmont, Maryland 2178 Dorothy Mackley - wife 21788 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Carcemation 3 Removal from State Stauffer Funeral Home 12/30/10 Frederick, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home Signature of Funeral Service Licenses 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Enysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 2 🗌 No detached 9 Unknown 9 Unknown cate has been signed by i page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA After this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: A Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29d. Date signed (Month, Day, Year) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donson

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 2010 DECEMBER Physician/ MALISZEWSKI ALOYSIUS 4c. County of Death Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL 8. Date of Birth (Month, Day, Dec • 31 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Pennsylvania 5. Social Security Numbe Days 1 X M 2 F Funeral Dec. 88 179-16-4734 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10b. County 10a, State 1X Yes 2 ☐ No event, the Medical Examiner must be notified at Director Frederick Frederick Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA ö 21702 1021 Dulaney Mill Drive Funeral 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. items 2 11. Marital Status 1 Never Married 2 Married white Completed by 1 ☐ Yes 2 X No Specify: ō 21215-0036 3 Widowed 4 Divorced 'natural", 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "1 Kraft Foods College (1-4 or 5+) Cheesemaker 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Maryland Stasia Shelinski Aloysius Maliszewski ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 should b of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 1021 Dulaney Mill Drive, Frederick, Maryland 21702 Ann Marie Gonzales - daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of Baltimore, 20a. Method of Disposition Stauffer Crematory Frederick, Maryland Stauffer Crematory permit. Page 1 a
Department of H
Important: If ite
any injury or otl 12-28-2010 1 D Burial 2 X Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition TNEUMONIA Physician/ Due to (or as a consequence of): Medical resulting in death) Examiner DEMENTIA Sequentially list conditions Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine attending physician and for use as the burlal-transit Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23d. Date of delivery IF FEMALE: Year 23b. Was decedent pregnant in the past 12 months? signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown Completed by 1 ☐ Yes 2 ☐ No BPH, 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an peen autopsy performed? Yes 2 No cate has page 2 s After this certificate 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be Other: examiner? 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA မ 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: work? Natural 5 Pending 2 | No Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Accident within 24 hours after death

To the Funeral Director: / 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier only one) 29b. Signature and title of certifier onekion 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHNSON DK,

State Registrar

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19 Day 2010 Year Physician/ Dec Month Nichol1 Рм Margaret 9:00 Claire Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Marlboro Prince George's 8511 Paragon Court if Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Aug 12, 1920 Days Hours Min. Philadelphia, Pa 90 177 14 5563 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho notified at Director 1 🗆 Yes 2 🛣 lo Upper Marlboro Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral United States 8511 Paragon Court 20772 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 ☐ Yes 2XX No If Yes, Give Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Sr. Associate other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I မ Ellen Connor Joseph Hetherington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary McGettigan (daughter) 8511 Paragon Court, Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 A Burial 2 Cremation 3 Removal from State Arlington National Cemetery Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria f Funera Salce Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Myseardial Physician/ disease or condition resulting in death) e minute Medical Due to (or as consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): vate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 Yes 2 No Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Ostes ather fis 1 Yes 2 No 3 Probably 4 Unknown Completed Myelo Lysplastic Syndrome Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical Hospital or Attending Physician: 26. Place of Death (Check only one) To Be examiner? Other: 1 \sum Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier D26287 reclans 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2B5 7305 Baltsmy Ba

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea, No ecedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Day Month Year M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 795 Annapolis Road Gambrills Anne **Arundel** Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign Days **4** M 2 □ F Months Hours Min. 03/2171934 213-36-1786 Director 76 Gambrills,MD Usual Residence of Decedent items 23a or 28a-f show ner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at agree. 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Gambrills 1 Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 795 Annapolis Road 21054 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Completed 3 Widowed 4 Divorced If Yes, Give 1 ☐ Yes 2 🔀 No Specify. Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Owner Elementary/Seconday (0-12) College (1-4 or 5+) Newspaper distribution 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Joseph O'Hara Mildred McNemar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley F. O'Hara 795 Annapolis Road Gambrills, MD 21054 Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) our Lady of the Fields 12/30/10 Millersville, MD 21. Signature of Foreral Service Licensee 22. Name and Address of Facility al Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and eat Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death Day n signed by the a ld be detached for Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 thinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ည 1 🗆 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending injurv 1 Yes 2 No Accident Investigation M filled in by the Sulcide 6 🗆 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 445 DEFENSE HWY, ANNA POLIS, M.D. 21401 UE 14A7-100-4 ^{Year)} 2 8 2010 Date filed (Mont) egistrar's Signature State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		State of Maryland / De	partment of Health and I	-	_								
	•	1 - State Consister Consis	ertificate of Death	Re	g. No.2 () ()	42703							
Physicia	n/	1. Decedent's Name <i>(First, Middle, Last)</i> Damian Orlowski		2. Date of Death Month	Day Year 20, 2010	3. Time of Death							
Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death								
LAGIIIII		6807 Irene Court	Boirie		Prince (Georges							
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday $148-44-2062$ 1 \cancel{X} M 2 \square F 59 Yrs.	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 2 Month, Day 2 18/195	9. Birtl	hplace (State o <i>r Foreign</i> Intry) I and							
		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or		12/10/130									
arylandia-f	ecto	10a. State 10b. County 10c. City, Town or the state 10	Location			10d. Inside City Limits 1 X Yes 2 □ No							
a or 28 be not	Funeral Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?							
ath with	uner	6807 Irene Court 11. Mantal Status 12. Was Decedent Ever in U.S. 13	20720	pecify Yes or No-	Poland 14. Race - Amer	ioan Indian							
fter dez	þ	1 Never Married 2 Married 1 Yes 2 No	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto Yes 2 No Specify: 	Rican, etc.)	Black, White								
ours a atural' cal Ex	Completed	3 ☐ Widowed 4 ☐ Divorced Year or Dates.	cedent's Usual Occupation	10	Specify: WII								
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ld be file Mental I arked o atic eve	To	Bronislaw Orlowski		Szypuls ka									
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) 19b. Ma Ireneusz Orlowski/Brother 680	iling Address (Street and Number or Run 7 Irene Court, Bow	ral Route Number, Clie, Mary 1	ity or Town, State, Zip and 2072	Code)							
ge 1 and it of Hez : If item or othe		1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State cemetery, ca	position (Name of rematory or other place)		Oc. Location - City or								
permit. Pa Departmer Important any injury once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Rob	ert E. Ev	ans Funer								
P P E G			6000 Annapolis Roa										
Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition As phy xiation by Hame Ing.											
Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Onset and Death Onset and Death Onset and Death											
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	in the past 12 months?	B		Month	Day Year							
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 ompleted filled in by the funeral director, page 2.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat (Check 2 Medical Examiner: On the basis of examination and/or inv	h occured at the time, date and place, a estigation, in my opinion, death occurred	at the time, date and	(s) and manner as sta place, and due to the c	ause(s) and manner stated.							
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10		Salvador Spretto Do	H003592	7 3	recember	122, 2010							
4.2		30. Name and address of person who completed cause of death (Item 23a) (Type Salvador Sulvesta 30c; Hospita	of Drive Cha	verla	Manyt	Poss d							
Stat Registra	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature	4.1	1)									
negistra	.10	person p. Loan	ne .										

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 23, 2010 Physician/ 10:15 AM M John J. O'Rourke Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Sandy Springs Friends Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours Min Maryland 1 X M 2 🗆 F Yrs 82 **Director** November 09, 1928 213-24-6990 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔀 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14612 Carona Drive Funeral U.S.A. 20905-12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced White er than "natura the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene. 27 is marked other than r traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Computer Technology 0 Manager 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) A.e., Marylan
A.e., mit. Page 1 and 2 should be file.
Department of Health and Merrimportant: If item 27 in
any injury or off ည Rosalie McDermott Patrick Francis O'Rourke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20905-Maryland Joan O'Rourke wife 14612 Carona Drive Silver Spring 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🗹 Cremation 3 🗀 Removal from State Mount Savage Maryland Saint Patrick's Cemetery 12/22/10 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ANMO disease or condition resulting in death) Medical Due to (or as a consequence of): [']Examiner KDRO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine FUITING as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 206010 and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: as been signed by the attending 2 should be detached for use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an STEORRITHRITIS certificate has autopsy page performed? 2 No 1 🗌 Yes Yes 2 No after death,

Director: After this certific

in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 1 No 1 Tyes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Tes 2 🗆 No 2 Accident 3 Suicide Investigation 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 12 19+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd-SILVER SPRING nas GLAHCY ML E 1731 BR1685 MAHEY 044 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Records, P.O. Box 68760

The law requires that the death certificate be executed in the law requires that the death certificate be executed in the law requires that the death certificate be executed in the law requirements that the law requirements the law requirements the law requirements that the law requirements the law requirements the law requirements that the law requirements the law r

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Per FH G911 1/18/2011 Jh State of Maryland / Department of Health and Mental Hygiene 2 1 1 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 AXINE 1930 FEIL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS, MARYLAND ANNE ARUNDEL 8. Date of Birth 1920 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗷 F Months Davs Hours Min. Director 90 05/24/2010 MINNESOTA 471-14-9640 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 XYes 2 No MD ANNAPOLIS ANNE ARUNDEL 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? ems 23a or Funeral 2717 RIVA ROAD 21401 12 Was Decedent Ever in LLS 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian "natural", or iten edical Examiner r Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: WHITE 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked ot ည JAMES A. JOHNSON IDA L. NELSON i. Page 1 and 2 should be thent of Health and Mentant: If item 27 is marke traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other t MAXINE P. CHEW - DAUGHTER 1273 BUGEYE COURT ANNAPOLIS, MD 21403 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place ÷ 5 Department of Important: If any injury or once. ARLINGTON NATIONAL CEM. 01/21/2011 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON, VA 21. Signature of Funeral Service Linense 22. Name and Address of Facility.ASTING TRIBUTES BY FELLOWS
IELFENBEIN & NEWNAM CREMATION & FUNERAL CA
314 BESTCATE ROAD ANNAPOLIS, MD 21401 FUNERAL CARE, P.A 23a part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final NEUMO Physician/ Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year Pregnant at time of death 1 ☐ Yes 2-☐ 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? 1 ☐ Yes 2 ☐ No Yes 2 No Physician: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 1_Natural 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier n438 2 Name and address of person who completed cause of death (Item 23a) (Type, Print) La PENTA in

DHMH 17 Rev 7/2009

State

Registrar

Fegistrar's Signature

27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 U 1 U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ December 20. 2010 Thomas 7:20 P M Proctor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Southern Maryland Hospital C1inton Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
March 5, 5. Social Security Number 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthdav) Funeral Months 1**x** x M 2 □ F 578-40-8511 77 °1933 Director Yrs Maryland Usual Residence of Decedent 10b County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director Marvland 1 Yes 2x No Prince George's Clinton 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 9211 Stuart Lane 20735 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ²□ № 1950þ 1 Never Married 2 X Married 1XX Yes If Yes, Give 1 ☐ Yes 2 A No Specify: 3 ☐ Widowed 4 ☐ Divorced Black "natural", Completed 1954 Year or Dates. d Mental Hygiene. marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Laborer Washington Gas Co. Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Arthur Proctor Harlev and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra Mary G. Proctor / Sister 23 Brazil Nut Lane Smithfield, North Carolina 27577 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cem. 01/04/2011 Cheltenham, Maryland ^{22. Name and Address of Facility}George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 21. Signature of Funeral Service Licenses also 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final End Stage Chronic Obstructure Pulmonay Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Year 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 2 No 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital: Other: ٩ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ceptifring Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated from Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29b. Signature and tit 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

Kichard

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

Palmer

DEC 2

00055120

1328 Southern avenue SE #310 Washington Oc 20032

Dec 21 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For
State
Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 24^{Day} Physician/ Month 12 2010 5:25 A M DANIEL HENRY PALMER Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death EASTON TALBOT 6245 BOSTON CLIFF ROAD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 **X** M 2 □ F 07/09/1935 DELAWARE 221-22-9719 75 Director Usual Residence of Decedent or 28a-f show notified at 10b County 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Tes 2 X No MD TALBOT EASTON 10f. Zip Code 10g. Citizen of What Country? ò 10e Street and Number must be r Funeral UNITED STATES 21601 6245 BOSTON CLIFF ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Was Decedent Ever Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 0 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) POULTRY EXTENSION SPECIALIST t. Page 1 and 2 should be filed with them of Health and Mental Hygien trant: If item 27 is marked other i jury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည MAMIE O. HENRY HOKE SMITH PALMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6245 BOSTON CLIFF ROAD, EASTON, MD BARBARA W. PALMER/WIFE Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State CHESAPEAKE CREMATION 12/28/2010 CENTER STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 5 Other (specify) Pregnant at time of death cate has been signed by the page 2 should be detached g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate I 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Director: A 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 12/28/2010 00053602 TIS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 508 IDLEWILD AVENUE, EASTON, MD 21601 CAROLYN HELMLY 31. Date filed (Month, Day, Year) Registrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene U | U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 17,201° Rufus Roland Jr. Aaron December 0600 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne **Arundel** If Under 1 Year If Under 24 Hrs. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours Days Min. West Virginia 1 M 2 - F 0917777932 234-44-9937 78 Director Yrs. Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked ther than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 43 West McKinsey Road 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Completed by 1 Never Married 2 Married 2 No 1 X Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 Year or Dates. Korea 1 ☐ Yes 2 😾 No Specify: 3 🛱 Widowed 4 🗆 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Utility Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Aaron Rufus Roland Bertha Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Roland 150 Hunter Drive West Hartford CT. 06107 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, Atlantic Crematory 12/20/2010 Glen Burnie,MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility 12 Ridgely Ave Annapolis, MD 21401 Hardesty Funeral Home P.A. se or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, dist only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final Onset and Death sician/ hemorrhagic day. disease or condition √ Nedical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has hear minned bounded. the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 DO N 1 ☐ Yes 2º No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Yes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🖾 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death. 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number michel, MD D69566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Parkway,

Registrar DHMH 17 Rev 7/2009 Michel

31. Date filed (Month

32. Registrar's Signature

Annapolis,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Bertha H. Rose December 2010 10:05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Spa Creek Center g. Birthplace (State or Foreign Country) West. Virginia If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 12/9/1914 5. Social Security Number **Funeral** 1 - M 2 - F Days Hours Min 96 233-72-6607 Yrs. Director West Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director 1 Yes 2 XNo Maryland Anne Arundel Annapolis 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? **Funeral** ral", or items 23a Ex miner must b 21401 USA 2918 Winters Chase Way 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 A No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White "natural" 3 X Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Home years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I ဂ္ Ella Creel Will Gustav Hiehle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health tem 27 Jayne R. Ross/ Daughter 2918 Winters Chase Way, Annapolis, MD 21401 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a
Department of h
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/17/10 Edgewater, Maryland Kalas Crematory 21. Signature Juneval Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Opset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown P.0. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, Hospital or Attending Physician: The law requires 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 100 Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide 5 Pending 1 🗌 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of Certifier 12/17/2010 d cause of death (Item 23a) (Type, Print) State 2 0 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Graham RUBESON DECEMBER 2010 1:05 A Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** QUEEN ANNE'S HOSPICE CENTER CENTREVILLE 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign Funeral 1 **X** M 2 □ F Months oCT. 4 1927 NEW YORK **Director** 83 017-22-3836 iral", or items 23a or 28a-f show Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🕱 No QUEEN ANNE'S CHESTER MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 102 GOLDENEYE COURT 21619 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼Yes 2 □ No
If Yes Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: WHITE "natural", Specify: Completed 3 Widowed 4 Divorced Year **494**5-1946 permit. Page 1 and 2 should be filled within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SALES REPRESENTATIVE ZEROX Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည STACY ROBESON ALYSS MACDOUGALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANE ROBESON/WIFE 102 GOLDENEYE COURT, CHESTER, MARYLAND, 21619 20a, Method of Disposition 20c. Location - City or Town, State CHESAPEARE CREMATION DEC. Date 9 1 ☐ Burlal 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CENTER 2010 STEVENSVILLE, MARYLAND Signature of Funeral Service License FEEDOWSAddrHELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. terval Between Immediate Cause (Final nset and Death Physician/ ADLIL ARBun disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner tryly going Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical phys the L IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown for 4 ☐ Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 🗌 No 1 Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other HOSPICE CENTER 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pendina 1 Yes 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ms nd address of person who completed cause of death (Item 23a) (Type, Print) JEFFREY 31. Date filed (Month, Pay, Year) Registrar's Signature State Registrar

Box 68760

P.0.

Division of Vital

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ VIRGINIA LEE CAPEL ROOF DECEMBER Medical 2010 4:07 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 118 MELVIN AVENUE GRASONVILLE QUEEN ANNE'S 5. Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. **Funeral** 8 Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Months Hours Min Director 214-42-8374 68 MARYLAND Usual Residence of Decedent Show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits MARYLAND QUEEN ANNE'S 1 Yes 2 X No GRASONVILLE 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 12 GRASONVILLE TERRACE 21638 UNITED STATES death 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 72 hours after Yes 2X No Maryland 21215-0036 1 Yes 2X No Specify: "natural", If Yes Give 3 Widowed 4 Divorced Specify. WHITE Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 10 College (1-4 or 5+ RETAIL MANAGER RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JAMES F. CAPEL MARIE JEWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 KIMBERLY A. ROOF/DAUGHTER 118 MELVIN AVENUE, GRASONVILLE, MARYLAND, 21638 other Baltimore, permit. Page 1 a Department of H Important: If ite 20h Place of Disposition (Name of CHESAPEAKE) CREMATION DEC. 29 20c. Location - City or Town, State injury or 1 Burial 2 Termation 3 Removal from State 4 Donation 5 Other (Specify) 2010 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licensee FELLOWS AND FENDEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND, 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician Onset and Death disease or condition concer Medical resulting in death) s a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) executed burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be after death. Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Other (specify) Pregnant at time of death Month Day Year 2 No be detached Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1

Yes 2

No 3

Probably 4

Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has pade perform death? certificate 1 Yes 2 X No 1 Tes within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? DAUGHTER'S Hospital Other: 1 Tes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother RECODENCE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) UKENS le and address of person who completed cause of death (Item 23a) (Type, Print) VILLE JEFFREY 2540 2 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month LYNNE HENDERSON RICH 0634 Decempe Medical 4b. City, Town, or Location of Death a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** 1001 If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Months Days Hours Min JUNE 14 Country) 69 NC Director 243-62-6323 Usual Residence of Decedent 3a or 28a-f show t be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 X Yes 2 No TALBOT EASTON MD 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral items 23a "natural", or items 23 UNITED STATES 27549 ASHBY DRIVE 21601 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: WHITE Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me once. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PROPRIETOR ATHLETIC CLUB Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ ALBERT HENDERSON CAROLYN MARLIN 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WARREN K. RICH / HUSBAND 27549 ASHBY DRIVE, EASTON, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION 12/21/2010 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA 200 SOUTH HARRISON ST., EASTON, MD 21601 JOHN MERC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. Approximate Interval Between Ousetrand Death vausi Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) -transit and that initiated events Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the buria Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Lire a. L. Pregnant at time of death in the past 12 months? Month Year Day 2 No signed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 s autopsy performed? death? 2 🗌 No 2 [25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20 12 10 D3988 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 8221 TEAL DR., STE. 301, EASTON, MD 21601 DAVID H. SMITH, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 22 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day LOUISE G. RICHARDS DEC 2010 Medical 7:00 Α 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death JULIA MANOR HEALTHCARE HAGERSTOWN WASHINGTON Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea 2/8/1925 Months Days Hours Min **Director** 236-28-7285 85 VIRGINIA Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director BERKELEY MARTINSBURG 1 🗌 Yes 2 💢 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 61 STONEY LICK ROAD 25403 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give XX
Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 ☐ No Il Hygiene. I other than "natural", Specify: 3 Widowed 4 Divorced Specify: Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SWITCHBOARD OPERATOR VA MEDICAL CENTER 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) uld be file Mental is marked permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or nate. ည GEORGE THOMAS FRAVEL LAURA ELLA FRAVEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHERYL GREGORY/DAUGHTER 61 STONEY LICK RD., MARTINSBURG, WV 25403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 30, 1 💢 Burial 2 🗌 Cremation 3 🗌 Removal from State DEC. PLEASANT VIEW MEM. GAR. 4 Donation 5 Other (Specify) MARTINSBURG, WV 2010 Signature of Funeral Service Licenses 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 327 W. KING ST. MARTINSBURG. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ 5 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Year Day signed by the aid be detached for Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Z Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street, Haverstown, MD 21740 Barbara Naden-Dlucher 3331111 31. Date filed (Month. gistrar's Signature State Registrar

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For AMEND#11, 12, 18, 206 State of Maryland / Department of Health and Mental Hygiene state per FH 1/3/2011 CVH AACO HEALTH DEPT Certificate of Death

1. Decedent's Name (First, Middle, Last)

Reg. No. Physician/ Month James Hollister Storrs 12/21 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Months Davs Hours Min. (Month, Day Year 4/9/1944 216-44-1975 Director 66 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director MD Anne Arundel Millersville 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1641 Isabella Ct. 21108 . Was Decedent Ever in U.S. Armed Forces?

1XX Yes 2 \sum No 1968
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2XX No Specify: Completed Specify 3XXWidowed 4 Divorced Year or Dates. Victnam 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Manager Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Health and Mental tem 27 is marked ည pe Joan Hile Joan Elizabeth Hile Gardner Hollister Storrs Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Storrs Wife 1641 Isabella Ct. Millersville, MD 21108 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial XX Cremation 3 Removal from State 12/24/2010 4 Donation 5 Other (Specify) Glen Burnie, MD Atlantic Crematory Signature of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. <u>Annapolis</u> Gambrills. 23a. Part 1. Enter the/disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a core Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Pregnant at time of death signed by the a 1 Yes 2 L 9 Unknown 9 Unknown P.0. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy page death? performed' 1 ☐ Yes 2 ☐ No ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** funeral director, Be 26. Place of Death (Check only one) Hospita Other: 1 Yes 2 No ဂ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Nesidence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. 2 Accident
3 Suicide 1 🗌 Yes 2 🗌 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier RAIVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 42

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Year

USA

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10d. Inside City Limits

Interval Between

Onset and Death

Year

Day

1 Yes 2XXNo

9. Birthplace (State or Foreign

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month,

Day, Year

DEC 2 8 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HINE Month 2350 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Harwood Mandrin Chesapeake Hospice House Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York . Age (In vrs. last birthdav) **Funeral** 8 Date of Rirth 1 🗆 M 2 🖊 F Min. March 3.1929 131-20-5079 81 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified as 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2554 West Course Drive 21401 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. White Completed 3 X Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Helga Hogberg Louis Berg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2404 Kelford Lane, Bowie, Maryland 20715 Pamela C. Norman / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Kalas Crematory 1 Burial 2 X Cremation 3 Removal from State 12-23-2010 |Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lie 22. Name and Address of Facility George P. Kalas Funeral Home Lite 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock in heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Beath Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any leading to immedic cause. Enter Underlying Cause (Disease or iinjury Due to for as a nonsequence of death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death the þ Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law I within 24 hours after death.

To the Funeral Director: After this certificate has be autopsy perform death? 2 🗌 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes ျှ 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA n 24 hours after death.

Per Funeral Director: After the pleted filled in by the funeral funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred House. injury 5 Pending work?
1 Yes 2 Accident
3 Suicide
4 Homicide 2 🗆 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific cember 2/20/0 who completed cause of death (Item 23a Type, Print) NNAPOUS MD 401 MM 445

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Box 68760

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2:58 PM Physician/ Month De Irene Snyder Medical 4a. Facility Name (if not institution, give street and number, Town, or Location of Death County of Death **Examiner** 9 If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours Min. 0872271929 West VA 216-24-3261 81 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at , or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Glen Burnie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 501 Marley Station Road 21060 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Solderer Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ernest Gibson Fansler Icie Isner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Ann Smith Daughter 501 Marley Station Road Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State veterans Cem 12/22/2010 MD Crownsville,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Hardesty Funeral Home P.A. Gambrills, MD 21054 ar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) to (or as a consequence of Due Examiner 4 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician if for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month 1 Yes 2 No 9 Unknown Month Year Day Pregnant at time of death sate has been signed by the page 2 should be detached Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 X No Other: 1 🗌 Yes Certificate: To within 24 hours after deau,

To the Funeral Director, After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Injury at 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending work 1 Tyes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 2010 who completed cause of death (Item 23a) (Type, Print)

Registrar
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State

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death OLENI SCHROCK Physician/ 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMRMO HUBGHBN CUMBERLAND Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of bill. (Month, Day, Year) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 XM 2 □ F Maryland 80 Director Sept. Usual Residence of Decedent 10d. Inside City Limits lid be filed within 72 hours after death with the Maryland Mental Hygiene. 10a, State 10c. City. Town or Location "natural", or items 23a or 28a-f sho dical Examiner must be notified at Director 1 🗌 Yes 2 🔀 No MD Garrett Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21536 USA 779 Springs Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. \$ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 Yes 2 X No Specify. White Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hours popartment of Health and Mental Hygelee. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical.I 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Farming Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sadie Hershberger Elmer Schrock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 779 Springs Rd., Grantsville, MD Miriam Schrock/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Dec. 30, 2010 Salisbury, PA Mountain View Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service License P.O. Box 275, Grantsville, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition CORONARY ATTACK - MYOCARMAZ IN FARCI Physician/ Medical resulting in death) Due to (or as a consequence of): yeurs **Examiner** SIGNIFICANT COLONARY OISBASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin ATHEROSCLEROSIS Cause (Disease or iinjury that initiated events resulting in death) Last requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): BETES MELLITUS Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABBATES MELLITUS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 1 ☐ Yes 2 🗷 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certifica completed filled in by the funeral director, to 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA ဂ္ 1 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)
PAVL JANOTKA MD ED WMRM ED KIMRMC, CUMBERLAND, MD

Registrar

31. Date filed (Mo

Baltimore, Maryland 21215-0036

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Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dec 22 Eric R. Speed 20:28 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Southern Maryland Hospital Clinton Prince George's 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Washington, DC Months Days Hours Min Oct 24. Director 579 70 1490 59 Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho idical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2 XXNo Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7206 Aquinas Ave 20772 United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes XXX Black, White, etc. 1 Never Married 2 Married þ 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 The Specify: If Yes, Give Specify: 3 Divorced 4 Divorced Completed **Black** Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Cook Restaurant Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alfred W. Speed Theresa Watkins permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele T. Howard (Sister) 8806 Monmouth Drive, Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State 4 Donation 5 Other (Specify) Lee Crematory Dec 27, 2010 Clinton, MD Signature of Funeral 89 22. Name and Address of FacilityLee Funeral Home, Inc 6633 Old Alexandria Ferry Road. Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Mus vardial Immediate Cause (Final a SJIM Onset and Death Priysiciani disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of if any leading to himself cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use and the con-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Other (specify) Month Day Year 4 ☐ Pregnant : 9 ☐ Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: ျင 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 🗶 ER/Outpatient 3 🗌 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

DHMH 17 Rev 7/2009

To the 1 within 2 To the 1

Registrar

(Check

29b. Signature and title of certifie

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 12/26/1

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day JAMES STOKES 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death UNIV. MARYLAND MEDICAL CENTER- STC BALTIMORE CITY ALTIMORE Social Security Number | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | Oct. 4. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Washington, **Director** 579-58-6819 64 Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1X Yes 2 □ No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral <u>1518 Br</u>yan Court 20601 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 X Divorced Year or Dates White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10th. Painter Union Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Albert Lionel Stokes Elizabeth Lewis permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic ence. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Cynthia Mistysyn/ Daughter</u> <u>108 Rolling Ave. North East, Maryland 21901</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 N Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Dec. 29, 2010 Waldorf, Maryland Heritage Mem Cem 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service Licenses MO 05 Old Washington Rd. Waldorf, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ SEPTIC SHOCK disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner NECROTIZING SOFT TISSUE Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Physician/Medical Examiner Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or linjury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery 1 Live Birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown in the past 12 months? Day Year 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIAZETES MELLITUS 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy performed? Yes 2 No certificate has prior to completion of cause of death? 1 Yes 1 Yes 2 No Be 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital Other: မ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certific 29c. License number RESOUD 12/21/10 UNIVERSITY OF MARPLAND MEDICAL CENTER RESOUU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 76B10 DENVILLE BALAMORD MYRIE 22 South CREENE ST

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Grace Struntz 0350 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death County of Death Examiner Kegional Medical Center Hiegany Cumberlana 8. Date of Birth 7. Age (In yrs. last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 🗆 M 2 🗶 F 85 219-54-2058 Waryland Director Usual Residence of Deceden "natural", or items 23a or 28a-f shov 10c. City, Town or Location should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** Maryland Allegany Frostburg 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 Hill Street U.S.A. 21532-12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) 4^{College (1-4 or 5+)} Elementary/Seconday (0-12) Teaching Elementary Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John W. Rollins, Sr. Ellen O'Connor permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532-Maryland Susan Yates daughter 40 Washington St Frostburg 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Saint Michael's Cemetery Frostburg Maryland December 29, 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 🗌 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Deat Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number who completed cause of death (Item 23a) (Type, Print) Cumberland MD 21502 now

Registrar
DHMH 17 Rev 7/2009

State

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Maybelle Dec. 19, 2010 10:10Sprey 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Talbot The Dixon House Easton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 22, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Months Hours 1 □ M 2√ F Yrs. 1914 PA 187-10-7778 96 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Talbot Easton 1 N Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 N. Higgins Street U.S.A. 21601 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2X No Specify. Specify: White 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert Roeder Beulah Beckhart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hansen / Daughter 1214 Jefferson Ave. St. Michaels, Md. 21663 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory | 12-21-2010 Salisbury, Md. 21. Signature of Funeral Service Licensee Hurley & Ostrowski Funeral Home P.A. LJoseph p.o. Box 518 St. Michaels, Md. 21663 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) imers Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Directo

Funeral

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show eny linjury or other traumetic event, the Medical Examinat he notified enone.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physicien: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and signed by the attending physician and I be detached for use as the burial-tran completely filled in by the funeral

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical þ Be Completed Certification: To

Medical

29b. Signature and title of ce

31. Date filed (Month, Day,

DEC 22 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ton

/32. Registrar's Signature

eausb. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1			23d. Date of delivery Month D	y Day Year
	contributing to death but not resulting in the underlying cause is the first of the second se	se given in Part I. yroidism,	23e. Did tobacco us 1 Yes 2 24a. Was an autopsy performed? 1 Yes 2	No 3 Probal 24b. Were autops prior to com death?	e cause of death? bly 4 Unknown sy findings available pletion of cause of
25. Was case referred to medical		26. Place of Death (C	heck only one)		
examiner? 1 ☐ Yes	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 \sum Nursing Home	5 ☐ Residence 6	Other (ASS)	isted Livi
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury	. Injury at 28d Work? 1 ☐ Yes 2 ☐ No	. Describe how injury	occurred	
3 ☐ Suicide 6 ☐ Could not be determined		ffice 28f.	Location (Street and City or Town, State)		Route Number,
29a. Certifier (Check only one) Certifying P	hysician: To the best of my knowledge, death occurred at miner: On the basis of examination and/or investigation, in and manner stated	the time, date and place, and my opinion, death occurred	d due to the cause(s) at the time, date and	and manner as sta place, and due to t	ited. the cause(s)

29c. License number

Cynwood Ar.

29d. Date signed (Month, Day, Year) 12/20/2010

DHMH 17 Rev 1/2001

Registrar

TLS

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar TCHD, 12/28/2010, TLS Amended, 11. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 22 Day INGEBORG GERDA SMERLING 2010 13:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 92 PARK LANE EASTON TALBOT 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days 1 🗆 M 2 🗶 F Months Hours Min. Country GERMANY 1171471924 Director 069-32-8447 86 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD TALBOT **EASTON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 92 PARK LANE USA 21601 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black White etc. 1 Never Married 2 X Me þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE If Yes Give 3 🛱 Widowed 4 🗌 Divorced Specify. Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 SECRETARY NEWSPAPER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ **ERICH VOSS** MARTHA HENTSCHEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANCY B. LITTREL, EXECUTOR 2815 STARR ROAD, QUEEN ANNE, MD 21657 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) WOODLAWN MEMORIAL 12/31/2010 EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
200 SOUTH HARRISON STREET, EASTON, MD 21601 JEHN iZ MFRCERO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Oncernand Death Physician/ disease or condition resulting in death) Medical Due to or s a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): use as the burialphysician Physician/Medical Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No for Month Day Year Pregnant at time of death g 🗌 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 2 N 1 ☐ Yes 2 ☐ No 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 🗌 Yes Certificate: To 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify, this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident work?
1 Yes 2 No 5 Pending 4 hours after death.

'uneral Director: Ai
ed filled in by the fu Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State, within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 125 ed cause of death (Item 23a) (Type, Print) person who compl 4 5386

State Registrar 31. Date filed (Month, Day, Year)

DEC 28 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene per MD, RG FCHD 12/29/10
Registrar Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month KRUM SUTCLIFFE DECEMBER :10 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 | F June 13, 1922 Months Hours Director Washington D.C. 216-32-8518 Usual Residence of Decedent 28a-f shov the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Frederick Knoxville 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 23a 1319 Rosemont Drive 21758 United States items hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. WWII 1 ☐ Yes 2 X No Specify: 3 ☑ Widowed 4 ☐ Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Survevor Land Surveying Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter D. Sutcliffe Edna Krum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Shewbridge/ Daughter 1319 Rosemont Avenue, Knoxville, Maryland 21758 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 Donation 5 J Other (Specify) Stauffer Crematory Inc. 12/29/10 Frederick, Maryland 21. Signature of Fue al Service Licensee 22 Name and Address of Facility autier Funeral Homes 1621 Opossumtown Pike, P. A. Frederick, Maryland 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Proviolani disease or condition resulting in death) Medical Due to (or as a consequent of): Examiner Urinary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). sician and burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months Month Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. completed filled in by the funeral director, page 2 should be detailed in the funeral director, page 2 should be detailed to the funeral director, page 2 should be detailed to the funeral director. 23e. Did tobacco use contribute to the cause of death? þ PNA, HIN Division of Vital Records, Hospital or Attending Physician: The law requires Aspi ratu 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at After t 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) D 66166 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

32. Registrar's Signature

400 West 7th Street, Frederick, Maryland 21701

M.D.

Mudusar Raza
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U 1 U State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Рм 6:33 DECEMBER 2010 CRICKETT STMPSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/31/1930 Birthplace (State or Foreign Country) Social Security Number 6. Sex Funeral 1 🕱 M 2 🗆 Months 214-28-6057 Director 80 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 ¥ Yes 2 □ No MD Frederick Frederick 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21701 473 Carrollton Drive ıral", or items 2 I Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12 Was Decedent Ever in LLS 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates. 1954–62 Specify. 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 6 truck_driver trucking permit. Page 1 and 2 should be filed wil Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt once. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Elmer B. Simpson Lillian Keplinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy Simpson-wife 473 Carrollton Drive, Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/31/2010 Frederick, MD Mount Olivet Signature of Funeral Service Licenses 22. Name and Address of FacilityStauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) attending physiclan for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death Unknown Yes 2 No been signed by the should be detached g Unknown P.0. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed? 1 🗌 Yes 2 🔲 No certificate Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital 2. No 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Médical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Regist ar's Signature

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death December Physician/ PEGGY JO SEALS 26. 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kline Hospice Frederick Mount Airy If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🖾 F Months Days Hours 11/28/1942 Director 412-68-7209 68 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Frederick Frederick 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21701 USA 604 Trail Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Certified Nursing Assistant Medical other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Lon Seals unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Reaver-former spouse 604 Trail Ave., Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gospel Cemetery | 12/29/2010 | Lisbon, MD 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, MD omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Part 1. Enter the disease, or shock, or heart failure List or Immediate Cause (Final Physician/ monar. disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events certificate be executed and-trans Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 1 Yes 2 9 Unknown Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Xves 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perforn After this certificate 2 🗆 No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospice House Other: 4 \(\subseteq\) Nursing Home \(5 \subseteq\) Residence \(6 \times\) Other (Specify) 2 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 1 Natural 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: within 24 hours after dearn.
To the Funeral Director: Aft 5 Pending 1 Tes 2 🗌 No Accident

3 Suicide

4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 | Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

TN

21702

Dav

Year

Approximate Interval Between

Onset and Death

4:45 AM

1 Yes 2 No

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

10

32. Registrar's Signature

	-	For State		State of	Maryla		epartment of H Certificate of D					2010	1,2727
		Registrar 1. Decedent's Name	e (First, Middle,	Last)			crimeate or B	Outri		. Date of Dea	Reg. No		3. Time of Death
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Examine	er			give street and numb	-		4b. City, Town, or Silve:		n of Death Spring		40	. County of Deat	tn
Funeral		5. Social Security N	umber	6. Sex 7	. Age (In yrs	. last birthda			er 24 Hrs. 8.	. Date of Birt	h v Year)	9. Bir	tholace (State or Foreign
Director		214-60-0 Usual Residence of		1 □ M 2 ■ F	5.5	5 Yrs	i. Months Days	110010	A	ugust	19,	1955 Wa	untry) shington,DC
land show d at	ģ	10a. State	10b. County		10c. C	City, Town or	Location						10d. Inside City Limits
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vith the 23a or	Funeral Director	10e, Street and Nur		Zinnia C	ircle		10f. Zip Code	0876	<i>.</i>		10g. Ci	itizen of What Co US	
death vitems	Fun	11. Marital Status		12. Was Deced		J.S. 1	3. Was Decedent of His If Yes, specify Cubar	spanic C	Orlgin? (Specify	y Yes or No-	П	14. Race - Ame Black, Whit	
al", or	d by	1 Never Marr		ed 1 Yes If Yes, Give Year or Date	2 No		1 ☐ Yes 2 ■ No						White
hours natur dical E	Completed	(Spe	15. Deceden	's Education	75.	16a. Decedent's Usual Occupation (Give kind of work done during most of working					16b. K	Kind of Business	Industry
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filed will Hygid I other vent, t	Be	17. Father's Name (nst)	·		111,01014		ther's Name (F	irst, Middle,		Surname)	
Ild be I Menta narked	ပ			ert K. Sc	hwartz								Schwartz
2 shouth and the and the and the and the and traum		19a. Informant's Na		p(Type, Print) tz/ Broth	er	19b. M	lailing Address (Street a 2006 Phill						
1 and of Heal item 2		20a. Method of Disp	position		20b	. Place of Di	sposition (Name of	1	Date	Т		ocation - City or	
. Page ment c tant: If jury or			■ Cremation 5 □ Other (S)	3 ☐ Removal from Specify)	tate		crematory or other place tropolitan ematorium	"	Dec.30	,2010	A1e	xandria	, Virginia
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	aniel O-	Pauler Il	CFSP		22. Name and Addres Moleswort 26401 Rid	ge F	Road, D	amascı	ıs,	uneral Marylan	Home d 20872
		shock, or hea	irt failure. List o	complications that can nly one cause on eac	used the de n line.	ath. Do not	enter the mode of dying	, such a	as cardiac or re	espiratory arr	rest,		Approximate Interval Between
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eath ce attend for us	Physician/M	23b. Was decedent in the past 12 1 Yes 2	months?	1 ☐ Live B 4 ☐ Pregna	irth 2 🗀 Fe ant at time o	etal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	У				23d. Date of de Month	Day Year
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ysicial is certi directo	To Be	examiner?		Hospital:	patient 2	☐ ER/Outpa	atient 3 DOA Othe	r'	eath (Check or Nursing Home		dence (6 ☐ Other (Spec	cify)
ing Ph		27. Manner of Deat	h 5 🗌 Pendin	28a. Date o	f injury , <i>Day</i> , <i>Year</i>)	28b. Tim inju	ry work	?		d. Describe h	ow inju	ry occurred	
Attend death ctor: A y the f	Certificate:	2 Accident 3 Suicide 4 Homicide	Investig	ot be	of Injury - At	home, farm	M 1 L '	Yes 2		f. Location (S	Street ar	nd Number or Ru	ıral Route Number,
tal or safter al Dire		4 Li Homicige	determi		g, etc. (Spec					City or Tow	n, State	e)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2	2 ☐ Medical E	caminer: On the basis	of examinat	tion and/or in	ath occured at the time, westigation, in my opinio ge, death occurred at the	n, death	occurred at the	e time, date a	ind place	e, and due to the	cause(s) and manner stated.
Vithi To th	_	29b. Signature and		,			29c. License				29d. Da	ate signed (Mont	
)				Jupanich			D OO	65	485		13	128/2	2010
12							500 Forest	G1er	n Road,	Silve	er S	pring,	MD 20910
Stat Registra		31. Date filed (Mont	th, Day, Year)		gistrar's Sign	nature	Sould						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 24,2010 CHARLES HAROLD SCOTT 1:19 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death 242 Knoxville Knoxville Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) an. 13,1938 Maryland 1 🔯 M 2 🗆 F Months Days Hours Min. **Director** 218-34-3906 Jan. Usual Residence of Decedent show If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2X No Maryland **Knoxville** Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 242 Knoxville Road 21758 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces
1 Yes 2 If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. Completed by 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: 3 ☒ Widowed 4 ☐ Divorced Black. Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Front End Loader Operator GenStar Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Raymond E. Scott t. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark Carrie Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jefferson Pike , Knoxville, Maryland 21758 Shelby May/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Moriah Baptist Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Mt. Knoxville, Maryland. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Funeral Service Signature Homes Pike, P. A. Frederick, Maryland 21702 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Immediate Cause (Final Cance Onset and Death Physician/ ancrecio disease or condition resulting in death) 1 year Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury s been signed by the attending physician and should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 4 ☐ Pregnant a 9 ☐ Unknown 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , 24 hours after deatn. e **Funeral Director.** After this certificate has be bleted filled in by the funeral director, page 2 s autopsy performed 1 Yes 2 No Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [within 2 To the I only one) 29b. Signature and title of certified 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar CX

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederich

32. Regist ar's Signature

5-7.

MD

20067691

21701

12-77-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dec. 22°, 2010° **Physician** Margaret K. Tvler 2:45 P M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Candle Light Cove Talbot Easton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | July 20, Year) | 1925 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 218-24-5745 1 □ M 2 □ F 85 Md. **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinant must be multiwed 1√Yes 2 No Director Md. Talbot St. Michaels 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 105 W. Chew Avenue 21663 U.S.A. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) School Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Be John Kemp Margaret E. Bridges ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Julia A. Hart / Daughter \$9 Longwood Drive, Mechanicsburg, Pa. 17050 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Salisbury Crematory 12-24-10 Salisbury, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Hurley Adrostrowski Funeral Home P.A. DSTROUGH. C.F.S.P. P.O. Box 518 St. Michaels, Md. 21663 Joseph 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Respiratory **Physician** disease or condition Xhours /Medical Due to (or as a consequence of): Examiner Truptogenic cirrhosis with asates Securitially not condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Be Completed by Physician/Medical the attending for use as 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 mophs? 3 Ectopic pregnancy Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 D I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown anattopenia. page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 1 No Hospital or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (SASSisted living 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

TUS

DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avenue

29c. License number

F. Seymour

29d. Date signed (Month, Day, Year)

December 23,2010

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Shirley Lee Underwood 7:23 P M 19 Decem<u>ber</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel 411 Bay View Drive Edgewater If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F May 1, 1936 West Virginia Director 577-48-3501 74 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland Edgewater Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21037 USA 411 Bay View Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Completed 3 X Widowed 4 □ Divorced Specify. White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Home 12th Homemaker Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ည Arnold Miller Naomi Elizabeth Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2A Harwood Drive, Harwood, Maryland 20776 Deborah L. Jordan/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XX Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature for Impray Sprvice Licensee 12/22/10 Edgewater, Maryland Kalas Crematory rvice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer pancreatic cancer Immediate Cause (Final Opset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending abused and attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 🗌 Yes 2 **X**No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 No 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 29d. Date signed (Month, Day, Year) 29b. Signature and fille of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medical PKway Annapolis, und. 2140/ E. Selonick, MO Straut 2003 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Crownsville Anne Arundel 376 Chestnut Trail 5. Social Security Number Year If Under 24 Hrs. g. Birthplace (State or Foreign Country) Pakistan If Under **Funeral** 6 Sex . Age (In vrs. last birthday) 8. Date of Birth Days (Month, Day, Year) 1/12/1937 Hours Min 1 DM 2 P 73 227-70-4215 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Crownsville 1 Yes XX No MD Anne Arundel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UK 21032 376 Chestnut Trail death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.
White 14. Race - American Indian, 2 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 24 No Specify. marked other than "natural", Completed Specify 3 Widowed 4 Divorced Year or Dates permit, Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Interior Design Decorator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Margaret Sumner Herbert Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 376 Chestnut Trail Crownsville, MD 21032 Raymond P. Gies 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/28/2010 Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility Hardesty Funeral Home, Signature of Funeral Service Gambrills, MD 21054 851 Annapolis Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Betwe shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immedicause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to for as a consequence off Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death the i 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 : autopsy performed Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier α

4/12

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

DEC 2 8 2010

Registrar's Signature

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print).
TENEVIEVE LIGHTFOOT-THY (LOR, 445 DEFENSE HWY, ANNAPOLIS, M.D. 2140).

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1^{M2}onth 16 Day 201 Oar Physician/ 1210 Richard J. Whitelock Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Prince Georges Hospital Center Cheverly Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 X M 2 🗆 F 10/28/1916 Maryland 94 Director 217-10-2065 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No MD Bowie P.G. County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12619 Kavanaugh Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 ☐ Yes 2 🗓 No If Yes, Give ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natuury or other traumatic event, the Medical ury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hair Style Barber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ <u>Leonard John Whitelock</u> Dora Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2724 Freshwater Way Odenton, MD 21113 19a. Informant's Name/Relationship (Type, Print) 2724 Freshwater Way Peggy Ford Evans Grandchild 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 4 ☐ Donation 5 ☐ Other (Specify) 12/20/2010 Glen Burnie,MD Atlantic Crematory Signature of Fine ervice Licenses 22. Name and Address of Facility 851 Annapolis Road Gambrills,MD 21054 Hardesty Funeral home P.A. and 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician ardiom Medical resulting in death) Due to (or as a consequence of) **Examiner** 10+01 if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine E Hospital or Attending Physician: The law requires that the death certificate be executed 124 hours after death. Francis of the second of Funeral Director. After this certificate has been sinned by the attending the second of as the burial-transi Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No g Unknown 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗶 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page performed? death? 1 Yes 2 **X**No 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 **X** No Other: 1 Tyes မ 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No after death Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the lawithin 2 To the law only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar D00 C

Prince Georges Hospital Center Cheverly, MD

12/16/12

20785

Asol ech

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

muchon

31. Date filed (Month

Mukemil Abdella MD

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Alfred Harry Werkheiser, Jr. Month 5:35 PM Dec 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5895 Fairforest Place Hughesville Charles Social Security Number 6. Sex 1 ★ M 2 □ F . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Feb. 9 4949 New Jersev 190 40 5956 61 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's Brandywine MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13810 Cherry Tree Crossing Rd. 20613 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 No Specify: White 1 ☐ Yes 2X No Specify: If Yes Give 3 Widowed 4 □ Divorced Year or Dates. 1967 – 69 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Carpenter Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred Harry Werkheiser, Sr. Anna Elizabeth Gebhardt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Wismer/Dtr.-in-law 15895 Fairforest Pl.Hughesville,MD 20637 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Chesapeake Crem. 12/27/2010Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd. Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 1 2 disease or condition ong resulting in death) Due to (or as a nsequence of): Sequentially list conditions, Day to for as a consequence of cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of). E FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day 5 Other (specify) Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)

Dtr-in-law

4 Nursing Home 5 Residence 6

28d. Describe how injury occurred

Physician/ Medical **Examiner**

Examine

Physician/Medical

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Completed

Be

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ertificate:

1 🗆 Yes

27. Manner of Death

1 Natural 2 Accident

Suicide

2 NO

5 \square Pending

Investigation

6 Could not be

Physician/

Medical

Examiner

Funeral

Director

show

28a-f s

23a or 2

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"natural"

permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any hiury or other traumatic event, the Meagnes.

the Medical

Examiner must be notified at

Director

Funeral

Completed by

Be

the Maryland

should be filed within 72 hours after death

3altimore, Maryland 21215-0036

burial-tran physician the burial certificate be Box 68760 attending pl sate has been signed by the page 2 should be detached P.O. Records, The law requires cate 2

DHMH 17 Rev 7	/2009		OPICINAL		
Regis		DEC 2.8.20	10 Serva B. Jan		
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	4.4	
761		30. Name and address of person who com	pleted cause of death (Item 23a) (Type, Print)	LePlake	MD 20646
5 5 cor		29b. Signature and title of certifier	tu	29c. License number D2F357	29d. Date signed (Month, Day, Year)
To the Hospi within 24 hou To the Funer completed fil	Medic	(Check 2 Medical Examine only one) 3 Certifying Nurse I	ian: To the best of my knowledge, death occur r: On the basis of examination and/or investigatio Practioner: To the best of my knowledge, death	on, in my opinion, death occurred a	and due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s) and manner stated. ace, and due to the cause(s) and manner as stated.
pital or Att ours after d eral Direct	al Certi	4 Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28c. Injury at

work?
1 Yes 2 No

28a. Date of injury (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert Thomas 11:00PMM Ward Dec Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9290 Taylor's Neck Road Nanjemoy Charles Sex 1 M 2 D F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Maryland Months Davs Hours Min. (Month, Pay, Year) 4 1 578-52-2043 69 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 1 😾 Yes 2 🗆 No Md. Charles Nanjemoy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9290 Taylor's Neck Road 20662 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? Black White, etc. ģ 1 Never Married 2 X Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: BLACK Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired other than Elementary/Seconday (0-12) College (1-4 or 5+) Private Industry Eviction Officer 12 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Importants If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Francis Doiver Ward Reb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9290 Taylor's Neck Rd., Nanjemoy, Md. 20662 Geraldine Ward/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) cemetery, crematory or other place, 12/31/10 Nanjemoy, Md. Hope Baptist 22. Name and Address of Facility Bluford Funeral Service 21. Signature of Funeral Service Licensee Min Martin Luther King Ave., Wash., DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 🗌 No cate has been signed by the a page 2 should be detached in 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed? Ves 2 No After this certificate 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 00 2 1 Yes ER/Outpatient 3 DOA 1 Inpatient 2 I 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending after death. Accident Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number filled in by 4 Homicide determined 24 hours a 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопріете (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

90

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 12 Month SARA COLLISON WARNER 2010 2:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death THE GARDENS OF WILLIAM HILL MANOR TALBOT **EASTON** Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X** F Days Hours Director 95 02/07/1915 252-32-8208 Usual Residence of Decedent In than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director EASTON TALBOT 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 545 CYNWOOD DRIVE, APT. E405 21601 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No ρ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Specify: WHITE Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72. It and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12 1 REGISTERED NURSE **HEALTH CARE** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ JOHN COLLISON MARY BRINSFIELD Lege 1 and 2 sh Legatment of Health and Important: If item 27 is m any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDY H. MCKINNEY/NIECE 651 NEW CUT ROAD, EARLEVILLE, MD Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State SPRING HILL CEMETERY 12/20/2010 4 Donation 5 Other (Specify) EASTON, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ HCV1) disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Atheroscherosis Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Examil burial-transi Chronic death certificate be executed Cause (Disease or linjury Kidne that initiated events resulting in death) Last Due to (or as a consequence of nding physician a Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Beath 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 Yes 2 No of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Sother (Specify) As + Livin funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending injury work?
1 ☐ Yes 2 ☐ No Division within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 1. Show RO77623 12-16-2010

Registrar
DHMH 17 Rev 7/2009

501 Dutchrais Lone

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

32. Registrar's Signature

State of Maryland /	Department of Health a	and Mental Hygien

1		1 - State of Maryland / Depa	rtment of Health and N tificate of Death		ne 10.2010 - 43.73
Physic	cian	Hegistrar Decedent's Name (First, Middle, Last) MARIAN LOUISE YATES		2. Date of Death Month	3. Time of Death 27. 2010 21: 20 14
/Med Exam		4a. Facility Name (If not institution, give street and number) FORT WASHINGTON MEDICAL CENTER	4b. City, Town, or Location of Death FORT WASHINGTON	1	dc. Jounty of Death PRINCE GEORGES
Funera Directo		5. Social Security Number 135–36–4677 6. Sex 7. Age (In yrs. last birthday) 8. Age (In yrs. l	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country) 1944 MISSISSIPPI
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. byther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	ctor	Usual Residence of Decedent 10a. State			10d. Inside City Limits 1 X]Yes 2 □ No
ith the	Director	10e. Street and Number	10f. Zip Code		Citizen of What Country?
Ind 21215-0036 be filed within 72 hours after death with the Marylar ital Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	1 Nover Married 2 Married 1 Nes Y No	Vas Decedent of Hispanic Origin? (Single Yes, specify Cuban, Mexican, Puert		ITED STATES 14. Race - American Indian, Black, White, etc.
Maryland 21215-0036 d 2 should be filed within 72 hours af th and Mental Hygiene. This marked other than "natural", or traumatic event, the Medical Exam	b	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates:	☐ Yes 2 No Specify: ent's Usual Occupation	ling 16b.	Specify: BLACK Kind of Business/Industry
21215 d within 7 giene. er than "r , the Med	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of wor O NOT use retired) BASE MANAGER	CC	OMMUNICATIONS
aryland 2 should be filed and Mental Hygi marked other umatic event, t	To Be (17. Father's Name (First, Middle, Last) MARK JOHNSON	ANNIE J	ne (First, Middle, Maid LOUISE MILI	LARD
Maryla d 2 should th and Mer 7 is marke traumatic		, ,	g Address (Street and Number or Ru		
Heal		20a. Method of Disposition 1 X Burial 2 Commation 3 Deemoval from State 20b. Place of Disposition cemetery, crem	natory or other place)	Date 20c.	Location - City or Town, State CLINTON, MARYLAND
Baltimol permit. Pages Department of Important: If it any injury or or		21. Signal Fun Service Licensee John 22	Name and Address of Facility		N HEAD, MARYLAND 20640
Physician /Medica Examine		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions,	er the mode of dying, such as cardiad	c or respiratory arrest,	Approximate Interval Between Onset and Death
8760, sate be executed only sician and the burial-transit	dical Examiner	Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.		.,	
O. Box 6 the death certific the attending p	Physician/Mec		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
'dS, P,		Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		co use contribute to the cause of death?
Division or Vital Records, P. or Attending Physician: The law requires that after death. Director: After this certificate has been signed by in by the funeral director, page 2 should be deta	Completed by			24a. Was an autopsy performed 1∐ Yes 2	24b. Were autopsy findings available prior to completion of cause of death? 1
Vita sician: certific rector,	B	25. Was case referred to medical examiner?	Othor	ath (Check only one)	- Tan (2 / 1)
on or ding Phys h. After this funeral di	tion: To	1 Yes 2 No 1 Inpatient 2 ER/Outpatien 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 1 Inpatient 2 ER/Outpatien 28a. Date of Injury (Month, Day Year) 1 Inpatient 2 ER/Outpatien 28b. Time of Injury Injury	1 3 DOA 4 Nursing P	28d. Describe how i	e 6 □Other (Specify) njury occurred
Division or Vital Record to the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, str. building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
e Hospit 124 hours e Funera Jetely fille	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of the basis of examination and/or in and manner stated.			
To th withir To th	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
RBIO)	30. Name and address of person who completed cause of death (Item 23a) (Type, ARVIND NARASIMHAN, M.D. 11711 LIVI	3	WASHINGTON,	MARYLAND 20744-5164
S	tate	31. Date filed (Month, Day, Xear) 32. Registrar's Signature 29 2010	back		

DHMH 17 Rev 1/2001

10-09946 James Attaasuako Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mes Attaasuako	1- For State	e of Maryland /	Departm Certific			and	Menta	al Hyg		g. No. 20	10	1.273	
Physician								2.	Date of Death		1 1	3. Time of Death	
edical Examine		ames Atta-A	suako	- 14	b. City, To		anation of l		December	24, 2010 4c. County of	Death	1505 hrs	
	4a. Facility Name (if not institution, of Shady Grove Adventist I			"	Rockvil		ocation on	Deall		Montgom			
Funeral	Social Security Number 6.	Sex 7. Age	(In yrs. last bir	thday)	If Under	_	If Under			`	9. Birth Cour	place (State or Foreign	
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any	Usual Residence of Decedent 10a, State 10b, County		Oc. City, Town	or Location	on							10d. Inside City Limits	
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h the Maryland 3a or 28a-f sho totified at once							20879			U.S.A.			
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fter de		ted If Yes, Give Year or Dates:	K No	1	Yes 2 2	No	specify:			Specify:		Black	
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and 2 should be filed within 72 hours after death with the Maryland teath and Maral Hygiew with 72 hours after death with the Maryland item 21 is marked other than "natural?, or items 23a or 28a-faht traumatic event, the Medical Examiner must be notified at once TO Be Completed by Elimeral Director		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z 8740 Airybrink Lane, Columbia, Maryland											
Baltimore, MD permit. Pages I and 2 sh Department of Health an Important: If item 27 in injury or other traumat	20a. Method of Disposition		20b, Place		tion (Name				Date :	20c. Location - (City or T	own, State	
Baltimore, permit. Pages I are Department of Hee Important: If ite Injury or other tr	1 X Burial 2 Cremation 4 Donation 5 Other Spec		Gate	-		Cer	n.	02/0	5/2011	Silver	Spr	ing, MD	
Balti permit. Departm Imports injury o	21. Signature of Funeral Service	censee	. 0.									Home, Inc.	
Physician	Nwa M. Juk 23a. Part I. Enter the disease, or co	mplications that caused to	he death. Do n	118 ot enter th	e mode of	dying, s	ampst uch as car	nire rdiac or n	espiratory arre	est, shock, or hear	SPI	ng, MD20904 Approximate Interval	
/Medical	failure. List only one cause on	i each line. _{a.} Smoke Inhalatior										Between Onset and Death	
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Sox 6876(leath certificate e attending phys for use as the be	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome			al death	3	Ectopic	pregnanc	су	23d. Date of o Month		ay Year	
Box 6876 e death certificate the attending phy ed for use as the l	TF FEMALE: 23b. Was decedent pregnant in the past 12 months? 7 1 Yes 2 No 9 Unknown	Pregnant at ti	- a of dansh		ner (Speci	fy)							
t the der	Part II. Other significant condition	9 Unknown	but not resultir	ng in the u	nderlying o	ause giv	ven in Part	t I.	23e. Did to	bacco use contrib	ute to t	he cause of death?	
ires that the signed by I be detach	<u></u>								1 Yes	2 No 3	Proba	ably 4 🗹 Unknown	
Division of Vital Records, tall or Attending Physician: The law requires as pare death. To a star death. To burctor: After this certificate has been so led in by the funeral director, page 2 should be a started for the page 1 should be a started for the page 2 should be a started for the page 3 should be a started for the page	ompleted ———————————————————————————————————								24a. Was a autops	sy pr	ior to co	opsy findings available empletion of cause of	
Reco	om o								perfor 1 ✓ Yes		eath? ✔ Yes	2 No	
Vital Recysician: The l	25. Was case referred to medical examiner?	Hospital:	at 2 ✓ ER/0) utmationt		· [c	of Death (0 Other			Residence 6	Other:		
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bou hou	29a Certifier .	sician: To the best of my				ime det	e and plac						
To the Hos within 24 h To the Fur completely	(Check only 1 Certifying Physical Examion 2) 2 Medical Examion 29b. Signature and title of certifier	iner:On the basis of exam and manner stated.	nination and/or	investigat	ion, in my	opinion,	death occ	urred at	the time, date	and place, and du	e to the	e cause(s)	
¥. ¥ £ 8	29b. Signature and title of certifier	and mariner stated.			29c.		number			29d. Date signe			
1 /	Caeol	Hallac	_			O.C.N	1.E.			December 2	25, 20		
Z/V	30. Name and address of person w Carol Allan, MD Assis	ho completed cause of de stant Medical Exam			Street, B	altimo	re, MD	21201					
Stat		32. Registrar			back								

		For State		Ce	ertificate o	f Death		F	Reg. No.		5-4-7
Physician	/ 1.	egistrar Decedent's Name (First, Middl	le,Last)					2. Date of De	ath Day Year		of Death
al Examine		JESSICA AN				4. Oh. Taura	Leasting of De	Decembe	er 11, 2010 4c. County of		0 hrs
	4:	a. Facility Name (if not institutio 645 Knights Island Ro		number)		Earleville	or Location of De	atri	Cecil	Death	
Funeral	5.	Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Y	ear If Under 24	Hrs. 8. Date of B	irth (MM/DD/YYYY)		State or Foreig
Director		UNKNOWN	1 M 2 X F	24	' L Yrs		ays Hours	Min. JULY	9, 1986	Country) MARYLA	AND
	_	sual Residence of Decedent	42						-,		
w any	11	0a. State 10b. County	CECIL	10c. City	y, Town or Loca		EVILLE				side City Limits Yes 2 🛣 No
or items 23a or 28a-f show must be notified at once.	┋┞	0e. Street and Number				10f. Zip Code			10g. Citizen of Wha		
the Maryland or 28a-f sh tified at once	[]	PO BOX 51				Tot. Zip code	21919		USA		
s 23a		1. Marital Status	12. Was Do	ecedent Ever in l	U.S. 13. Wa	as Decedent of I		Specify Yes or N		American India	an, Black,
or items 23 must be no		Never Married 2 Married	arried Armed	Forces?	lf Y	res, specify Cub	oan, Mexican, Pu	erto Rican, etc.)	White,		,
ral", o		3 Widowed 4 Div	orced If Yes, Give Y			Yes 21				WHITE	
Exam		15. Decedent's Education (Spe					pation (Give kind ife. DO NOT use		16b. Kind of Busi	ness/Industry	
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ent, ti		GREGORY BEECH	IER				KIMBE	RLY HOWE	LL		
tic g	2 1	9a. Informant's Name/Relations	ship (Type, Print)			•			umber, City or Town,	State, Zip Coo	de)
Tauma		GREGORY N. BEE	CHER- FA		PO Place of Dispos			LLE, MD 2	21919 20c. Location - 0	ity or Town S	tate
of He If ite	- 1	Burial 2 X Cremation	n 3 Removal	from State	crematory or of	ther place)					
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygient Department of Health and Mental Hygient and Latens 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once To Re Commission Hygient Standard Page 10 insertor	2	1. Signature of Funeral Service 3a. Part I. Enter the lise use, or	Licensee		1 62	Name and Addre	ess of Facility C	HARLES S	. ZEILER IMORE, MD	& SON] 21224 t Appro	INC.
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 1 - State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death BAYNES Month 12 **Physician** 10 Year 3 T 10:06a -WIT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Sinai Hospital Baltimore
Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours Min. 1 M 2 F Yrs 225-38-3417 Director 09 22 33 VA Usual Residence of Decedent with the Maryland show 10a. State 10b. County 10c. City, Town or Location or 28a-f show protified at 10d. Inside City Limits Director 1 Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be 3304 Barrington Road 21215 Funeral U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City r than Elementary/Secondary (0-12) College (1-4or 5+) Educator Public Schools 12th 6 Years other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental 7 is marked o traumatic eve Lucy Reed Emmett Pugh 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 is permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr 21215 3304 Barrington Rd. Baltimore, Md. Holice R. Baynes-husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, Md. Garrison Forest Vet 1-7-11 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Name and Address of Facility
March F/H West 4300 Wabash Ave., Baltimore Md. 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acuta myo commen INFAPETION 1 HOUR /Medical Due to (or as a consequence of) Examiner HIMETO SCHELLIC 13154765 CAPADIOU ARCULA 30 15 W So que nifelly list could significantly, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed ナイトにみ しれのしでき プラチのしに SCHEADS burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical Hyp Exprosion 30 45-436 the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 autopsy performed death? 1 ☐ Yes certificate 2□ No 1∐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 2 ER/Outpatient 3 DOA ၉ 1 Inpatient funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation Injury dea h. 1 □ Yes 2 □ No the Funeral Director mpletely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide afer Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 24 and manner stated. To the within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) D 30406 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and WASHINGTON BWD Burmose レベチ 000 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner ENTER 121 SING Social Security Number if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 M 2 🗆 F Days Hours Min **Director** ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Am Bridge 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Completed 3 - Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) INCLUSTRIAL HANICO Oreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address Street and Number or Rural Route Number, City or Town, State, AMBILIDA -daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service License and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause she each lin Approximate Interval Betw Immediate Cause (Final Onset and Death Physician Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine build to (or se's conecquence of) The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? be detached for Month Day Year 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy performed' death? 2 No Yes Division of Vital To the Hospital or Attending Physician: completed filled in by the funeral director. 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospita Other: 2 🔼 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No M Natural s after death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State, within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, WAL 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SADW 4333 20708 16 Date filed (Month, Day, Year, 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

JAN 1 4 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ Kyree Brooks 3 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Square osedale more If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day 1 🖾 M 2 🗆 F Min. 36 Country)
Maryland Days Hours Director INFANT 2010 Usual Residence of Decedent 10a. State death with the Maryland "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Perry Hall 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 510 Honeybrook Way 21128 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Page 1 and 2 should be filed within 72 hours after in the Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 K No Specify. Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than " Callege (1-4 or 5+) INFANT Elementary/Seconday (0-12) INFANT INFANT INFANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once. Devonte Antwon Brooks Monica Monet Still 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monica Still - mother 510 Honeybrook Way; Perry Hall, Maryland 21128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🗷 other (Specify) in State 22. Name and Address of Facility State Anatomy Board 21. Signature of Funer Project Idenses RO I Q Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ Due to (or as a consequence of): disease or condition resulting in death) Casdiac Medical Examiner maturit Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 2 No 1 Yes Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certified To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu**y** and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Duzano Drive

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 3 State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg, No. For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Year Unknown M MARY ESTELLE CLARK 12 2010 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** Kanda lymore Istown Dag 8. Date of Birth (Month, Day, Year) 2-6-/938 Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 1 🗆 M 2 🔽 Yrs. mi **Director** Jsual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10d. Inside City Limits Director 1 Yes 2 No MU STOWN anda 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral Dao 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) USA Han we . Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Completed by 1 Newer Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 2 No 1 ☐ Yes 2 ☑ No Specify: Black 3 ₩idowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Be Father's Name (First, Middle, Last) 18. Mothe 2 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, redow 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Hypertensive Car many 10 in Medical Due to (or as a consequence of) Examiner Millitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed the 24 hours after death. Cause (Disease or iinjury that initiated events resulting in death) Last Hymelim demin sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' Director: After this certificate 2 🗌 No Yes 2 No Yes δmpleted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 2 **N**0 Other: 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12011 215938 6

State Registrar old

Comb Rd # 201

Remobiliston Md 2113 3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5400

Registrar's Signature

M.D

M- YUNYONGTING
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene Amend Item 23aPtI,25 per me,g911,01/12/2011dhb

Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) of Death Physician/ Medical wih 4a. Facility Name (if not institution, give street and numb n, or Location of Death **Examiner** 4c. County of Death mon TIMORE 9. Birthplace Country) **Funeral** Nate of Birth Months Director or 28a-f show 10b. County 10d. Inside City Limits any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 □ No more 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a o Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☑ Never Married 2 ☐ Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working ife. DO NOT use repred) (Specify only highest grade completed) College (1-4 or 5+) ustodian Be 's Name (First, Middle, 's Name (First, Middle ၉ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number olborne 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12-28-10 Marriotsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 23. Nama and Agoress Greener Funeral Si51 Baltimore National 21. Signature of Funeral Service Live 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 201 Onset and Death VO 1 Pnysician/ disease or condition Medical resulting in death) Examiner Birth Defect Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) AL EXAMINER attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 2 3 N Yes 25. Was case referred to Be 26. Place of Death (Check only one) examiner? Hospital: Other ျဉ 1 Inpatient 2 ER/Outpatient 3 DOA Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ☐ Natural injury work? 5 Pending 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Registrar's Signature

State Registrar

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 42744 State of Maryland / Department of Health and Mental Hygiene

		I- For State Registrar			Certific	cate of	Death				Reg. No.		
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		4a. Facility Name (if not institution Johns Hopkins Hospit		umber)	•	4	b. City, Town, o Baltimore	or Location	of Death		4c. County	of Death	
Funeral Director		5. Social Security Number 218-74-5095	6. Sex		n yrs, last bi	irthday) Yrs.	If Under 1 Ye Months Da				3-1960	Foreig	
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Ŋ	3	00. Name and address of person									1, 1		
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Charles Wilkes Christian	State of Maryland / Department of Health and Mental Hygiene	,

		I- For State Registrar		Certii	ficate of I	Death					Reg. N	lo.			
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Funeral		5. Social Security Number	6. S ex	7. Age (In yrs. last	birthday)	If Under 1 \	ear aγs	If Under 2 Hours	24Hrs. Min.		•		9. Birth Foreign	place (State or	
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21215-0036 July be filed within 7 Mental Hygiene. In marked other than ic event, the Medica	To B	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailing	Address (S	treet a	and Numb	er or Ru	ral Route I	Number	, City or Towr	n, State,	Zip Code)	
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/Medical		failur List only one cause on each line. Subarachnoid Hemorrhage with Intraventricular Between Onset and Immediate Cause (Final disease a. Hemorrhage post aneurysmal repair of basilar artery Death													
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587 srtific ling p	an/	23b. Was decedent pregnant in t past 12 months?	I FIAB	birth	2 Feta	al death	3	Ectopic p	pregnan	су		Month	Da	ay Year	
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Divi spital or , tours after neral Dir	Certification;	4 Homicide determined (Specify) local street Baltimore City, Md.													
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		Tollogi only		est of my knowledge											
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				al Examiner		itimore St	reet,	Baltim	ore, M	שוביים ליו 					
S Regis	tate trar	31. Date filed (Month, Day, Year JAN 1 3 20	11 Sepan	Registrar's Signature	backer	•									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Charles Diemesor 2010 42746 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle Last) 2. Date of Death Physician/ Month Day December 27, 2010 Charles Onajite Diemesor, **Medical Examiner** 1545 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Johns Hopkins Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 214-49-1116 13 01/10/1997 Country) MD 1 X M 2 F Yrs Usual Residence of Decedent 10c Cify Town or Location 10d. Inside City Limits 10a State 10b County 1 X Yes 2 No MD Baltimore within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2812 Westfield Avenue 21214 12. Was Decedent Ever in U.S. 14, Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: Black 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical timore. MD 21215-0036 Middle School 8th Student of Health and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be filed Charles Onajite Diemesor, Sr. Emma Dohjenka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma Diemesor - Mother 2812 Westfield Ave. Baltimore, MD 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State : If i crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Baltimore, MD 1/22/11 Paran Pre.Cem. Mt. Donation 5 Other Specify Signature of Funeral Service License 22. Name and Address of Facility 4300 Wabash Avenue March FH West 21215 Baltimore, MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval dilure. List only one cause on each line Between Onset and /Medical a. Gunshot Wound of Head Death nediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and cian/Medical ttending physician a UNPENDED AMENDED Records, P.O. Box 68760, IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed s been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate has performed Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Other₄ Nursing Home 5 Residence 6 this 1 🗸 Yes 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Dec 27, 2010 Subject shot Natural 1510 hrs 5 Pending Director: 1 Yes 2 V No death. 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 2812 Westfield Avenue, Baltimore, Md (Specify) residence 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) Medi and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 28, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Mb/A/A/Day Ye2r) 20 . Registrar's Signature MACHIL Registra

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. lend #31 Per DVR G911 1/13/2011 Jh
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death loe Month Physician/ 2245M uque ay Dec Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Genera to wa rd sunta 0 moia 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Se If Under 1 Year If Under 24 Hrs . Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 L Director 2010 INFANT Usual Residence of Decedent ar than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Columbia Howard MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21044 11249-A Slalom Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) INFANT INFANT INFANT INFANT Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed thent of Health and Mental H rtant: If item 27 is marked ot jury or other traumatic even မ Jose Dugue Tamara Dugue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 11249-A Slalom Ln; Columbia, Maryland 21044 Tamara Dugue 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in State cemetery, crematory or other place) Department of Important: If any injury or 22. Name and Address of Facility State Anatomy Board . Signature Funeral Service Licensee Wadte rector 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final XIZEME MAJULI Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any heading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year 5 Other (specify) 1 Yes 2 cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perform death? Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Tyes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation 2 No Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on 29b. Signature and title 29d. Date signed (Month, Day, Year) 31. 2010 person who completed cause of death (Item 23a) (Type, Print 30. Name and address of 00000 Registrar's Signa 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Decembe Medical 4a. Facility Name (Not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6. Sex (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 K 9 Month Day, Year 913 Months Days Hours Min. Country) West 220-43-4493 Director Indies Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be norther an once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Baltimore Randallstown MD 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4355 Chapeldale Road 21133 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify. 3X Widowed 4 ☐ Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Laundry Laundress 12th N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hall Francella Everet Jeremiah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monica Gordon-daughter 4355 Chapeldale Road Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 01/09/11 Sykesville, MD Lakeview Mem. Park □ Donation 5 □ Other (Specify) 21. S g 22. Name and Address of Facility e of Funeral Service Licensee MARCH FUNERAL HOME-WEST 4300 MD 21215 Wabash Avenue Baltimore, 23a. Part 1. Enter the disease, or complications that caused shock, or hear dailure. List only one cause on each line sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or a the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death ed by the detached Unknown 9 been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sate has page 2 s autopsy performe 2 X No certificate Yes 2 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To Other: within 24 hours after cream.

To the Funeral Director: After this of a committee filled in by the funeral dilled in by the funeral dilled. 1 🗌 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Deat 28c. Injury at work? 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending 1 🗆 Yes 2 🗆 No Investigation Suicide 6 Could not be ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number H0055644 29b. Signature 29d. Date signed (Month, Day, Year) December 29, 2010 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 5401 od covet Rd Roudallstown M) 21183 LORY Jenniter 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JONES IE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Place Eutaw <u>Baltimore</u> 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. (Month, Day, Year) Director 214-20-8844 84 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 XYes 2 ☐ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2415 Eutaw Place Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Bace - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 2 XNo ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: "natural". 3X Widowed 4 □ Divorced Completed Black Year or Dates is marked other than "natur aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 12th grade College (1-4 or 5+) **2yrs** Mental Hygiene. Social Security Adm Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ones. မ Mary Purdy Willie Chambers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3691 Forest Hill Road, <u>Pamela Mullen-Daughter</u> Baltimore, Mđ 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) On-Site 1/4/2011 Baltimore, Md 21. Signature of Funeral Service License 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate

Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death 5 Other (specify) signed by the detached g 🔲 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by completed filled in by the funeral director, page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 certificate ! 1 Yes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred Matural 🔀 injury 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Description of the descri 29a. Certifier (Check within 2 To the I 29b. Signature and title of certifier 29c. License numbe

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signa

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Aaryland 28a-f show 1 at ooce	ctor	10e. Street and Number			TOIMOI	10f. Zip	Code				10g.	Citizen of Wha	t Count	
MOCE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. tot: If item 27 is marked other thao "oatural", or items 23a or 28s-f show other traumatic eveet, the Medical Examiner must be sotified at socce.	Director	501 Dolphin	Street				1217			USA				
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Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	10 B	19a. Informant's Name/Relation	The second second second			_	(Street	and Numb	er or Ru	ıral Route	Number	r, City or Town		
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	ž	29b. Signature and title of certi	fier	1/ 304	D	29	c. License					9d. Date signe December 2		
		30. Name and eddress of person	De Viel	lies of death /lies	n 23el		O.C.N	i. E.	_			, svembel ,		10
		Victor Weedn MD JE	Assistant M	edical Exami		W. Baltii	more St	reet, Ba	ltimor	e, MD 2	1223			
	tate	31. Date filed (Month, Day, Yea	2011	Registrar's Signat	ure	Mal								
Regis	uar	OTMAL	GUII ARM	me 10	160 66	A COL								

DHMH 17 Rev 1/2001 OCME 2006

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		_	Please	State of I				K. Ensure Health and	-		Legible.		
		For State Registrar					tificate of			Reg. No.	010	42751	
Physician/ Medical		1. Decedent's Name (First, Middle, La	st) KA	Tze	NE	CR96	er	2. Date of De Month	ath Day	Year	3. Time of Death 1623 M	
Examin		4a. Facility Name (if not institution, give street and number))	4b. City, fown, or Location of Death			th	4c. County of Death			
Funeral Director		5. Social Security Num 213-28-39		Sex 7.7	Age (In yrs. Ia		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th y, Ye <i>ar</i>) 1930	9. Bird Coo Mar	thplace (State or Foreign untry) y land	
land show dat	tor	Usual Residence of Decedent 10a. State 10b. County				10c. City, Town or Location						10d. Inside City Limits	
the Mary or 28a-f	Funeral Director	MD 10e. Street and Number			Baltimore 10f. Zip Code					1 ☐ Yes 2 🖾 10g. Citizen of What Country?			
ath with 'ms 23a 'must b	uneral	773 W. (12. Was Deceden	t Ever in 119	3 112 1/	21230 13. Was Decedent of Hispanic Origin? (Sp			USA	de estados			
rs after death with the Maryland rral", or items 23a or 28a-f show Examiner must be notified at	by	1 ☐ Never Married 2 ♣ Married 3 ☐ Widowed 4 ☐ Divorced		Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:			to Rican, etc.)	acify Yes or No- Rican, etc.) 14. Race - American Ind Black, White, etc. Specify: White			
i 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho r traumatic event, the Medical Examiner must be notified at			Education rade completed) College (1-4 o	r 5+)	(Give k life, DC	Sa. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired) printer			16b. Kind	of Business	Industry		
d be filed w fental Hygi irked other tric event, t		17. Father's Name (First, Middle, Last) Leo Katzenberger				18. Mother's Name			me <i>(First, Middle,</i> in Kronei	e (First, Middle, Maiden Surname) n Kroner			
12 should alth and N 27 is ma r trauma		19a. Informant's Name/Relationship (Type, Print) Jean Katzenberger – wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 773 W. Cross St; Baltimore, Maryland 212					,	
age 1 and ent of Hea nt: If item y or othe		20a. Method of Dispos	Cremation 3	Removal from Sta	te c	Place of Disposemetery, crem	sition (Name of eatory or other pla	ce)	Date	20c. Loca	ation - City or	Town, State	
permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en		21. Signature of Fune ROT			rector			ess of Facility St Baltimore				yland 21201	
			ailure. List only o	pplications that caus one cause on each I	ed the death	n. Do not ente	r the mode of dyir	ng, such as cardiac	or respiratory ar			Approximate Interval Between Onset and Death	
Physician/ Medical Examiner		Immediat Cause (Fir disease or condition resulting in death)	nai	a	s a sonse u	(M) Jenje ori.	diven	V CA	-			Oriset and Death	
	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or inlininy that initiated events resulting in death) Last Due to (or as a ponse uente of). Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):											
be executed sician and burial-transit	cal Exan	Cause (Disease or linjury that initiated events resulting in death) Last c. Due to (or as a consequence of):											
To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pr in the past 12 mo 1 Yes 2 1 t 9 Unknown	onths?	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknown	n 2 🗌 Feta at time of d	I death 3 🗌	Ectopic pregnan Other (specify)	NA		23	d. Date of del	ivery Day Year	
es that th signed by I be deta	þ	Part II. Other significant conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions conditions contributing to death but not result to the conditions conditions contributing to death but not result to the conditions condit				ulting In the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ M 3 ☐ Probably 4 ☐ Unknown			
e law requir e has been ge 2 should	Completed	INSUMNIA							24a. Was				
ian: Th	To Be	25. Was case referred examiner?	to medical				26. P	lace of Death (Che	1 🗆 Yes	2 144	1 🗆 Yes	2/ S -No	
Physic r this ce eral direc		1 Yes 2	<u></u>	28a. Date of in	jury	ER/Outpatient 28b. Time of	3 □ DOA Oth	4 □ Nursing F	dome 5 Resid			ffy)	
ttending death. tor: Afte the fune	Certificate:	1				injury work? M 1 □ Yes 2 □ No me, farm, street, factory, office				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
urs after ral Direc		4 Homicide determined 28e. Place of Injury - At hor building, etc. (Specify)							City or Tow				
he Hosp iin 24 ho he Fune	Medical	29a. Certifier (Check 2 Conly one) 3 C	Medical Exam	sician: To the best of iner: On the basis of se Practioner: To the	examination	and/or investi	gation, in my opini	on, death occurred	at the time, date a	nd place, ar	nd due to the c	ause(s) and manner stated	
Noth		29b. Signature and title of certifier Answer Our L				29c. License number				29d. Date signed (Mgnth, Day, Year)			
		30. Name and address	s of person who	completed cause of	death (Item	23a) (Type, Pr	int) WI A	ent.s	t Ba	H N	121	223	
Stat Registra	-	31. Date filed (Month, I	Day, Year)	o2. Regis	trar's Signat		1		<u></u>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Physician/ December 6:12 PM Lundy 2010 Charlie 24 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Cita Sinai Baltimone Hospital Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Hours (Month, Day, Year) Months Min. 1 XM 2 - F Director 231-22-5808 85 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 U.S.A. 2137 Chelsea Terrace 12. Was Decedent Ever in U.S. Armed Forces?
1 ✓ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married CHARLES 3altimore, Maryland 21215-0036 1 ☐ Yes 🗶 No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Worker Bethlehem Steel 6th grade na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LUNDY, ည <u>Viola Whyte</u> Herbert Lundy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chelsea Terrace, Baltimore, Md 21216 Joanne Morris-Friend
20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town. State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 1/7/2011 Crownsville, Md Crownsville 21. Signature of Funeral Service License 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Severe Physician/ Metabolic disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or s a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Dav Year Pregnant at time of death the detached 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No certificate 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 16 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, Thaudhary

State Registrar

DHMH 17 Rev 7/2009

SINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHAUDHARY

32. Registrar's Signature

JYDTI

31. Date filed (Month, Day, Year)

JAN 1 9 2011

18

BALTIMORE

OF

HOSPITAL

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Edmund Scott Led		- For State	State	of Marylan			t of Healt e of Death		tal Hygiene	Per No	010	42753
Physicia	R	enistrar	e (First, Middle,Las	t)		moate			2. Date of De		'ear	3. Time of Death
Medical Examin	er	Edmund	Scott Led	ler						er 29, 2010		1027 hrs
12	4		if not institution, giv		ber)		4b. City, T Salisb	own, or Location o	of Death	4c. Count	ty of Death nico	
			Regional Medi		. Age (In yrs. Ia	ast hirthda			er 24Hrs. 8. Date of B		YY) 9. Birt	thplace (State or Foreign
Funeral Director		5. Social Security N	-3688 ₁¤	M 2 F	55	ast billinga		Days Hours		3, 1955	Col	v York
any		Jsual Residence o 10a. State	of Decedent 10b. County		10c. City,	Town or l	Location					10d. Inside City Limits
		MD	Worces	ter	Sn	ow H	i11					1 Yes 2 X No
ne Maryland or 28a-f show fied at once.	Director	10e. Street and Nu					10f. Zip			10g. Citizen of	What Cour	ntry?
= • •		301 S.	Church S	t; Apt 2	203			863		USA		
n with	Funeral	11. Marital Status	ied 2 X Married	12. Was Dece		.S. 13	Was Decede If Yes, specif	nt of Hispanic Orig y Cuban, Mexican	gin? (Specify Yes or I n, Puerto Rican, etc.)		ace - Ameri hite, etc.	ican Indian, Black,
r death	딃			1 X Yes	2 No		1 Ves 2	X No specify:		Specia	_{fy:} whi≀	te
rs afte	<u>a</u>	3 Widowed	ducation (Specify c	or Dates:	completed)	16a. Dec	cedent's Usual	Occupation (Give	kind of work done	16b. Kind of		
2 hou	Completed	Elementary/Sec		College (1-			· ·	king life. DO NOT	use retired)			
036 ithin 7 ane. r than	ם	12		8		С	ommunic		r's Name (First, Middle		ernme	nt
215-0036 be filed within 7 natal Hygiene. rked other than			(First, Middle, Last)					rs Name (First, Middi cma Danett		ille)	
2121 2121 Suld be f Mental marked ic event	Be	Alvin	Leder lame/Relationship (Type, Print)		19b. N	Mailing Address		mber or Rural Route		Fown, State	e, Zip Code)
MD 2 id 2 shou ulth and N m 27 is n	리		Spide - f			3	01 S. C	Church St	Apt 203;			
e, N I and Health item	Ì	20a. Method of Di	sposition				Disposition (Nai or other place	ne of cemetery,	Date	20c. Locati	on - City or	r Town, State
MOF Pages ent of nt: If			Cremation 3 Other Specification 3 3 3 3 3 3 3 3 3		III State					1.7		
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	1		reral Service Lice			r			^{ty} State An			01001
	اع	/XV nn	1/////				655 V	7. Baltin	nore St; B cardiac or respiratory	altimore arrest, shock, or	n heart	Approximate Interval
Physician Medical		failure. List o	only one cause on e	each line.								Between Onset and Death
₹xaminer	ĺ	Immediate Cause or condition resul	(Atherosclere			Disease					
		Sequentially list of	conditions, t)								
	iner	if any, leading to	immediate derlying Cause ,	Due to (or as a	consequence	of):						ы.
.=	Examiner	(Disease or injury events resulting i		Due to (or as a	consequence	of):						
O, e be executed ysician and burial - transit	ia E			AMENDED								
O, e be execut ysician and burial - tra	edical	UNPENDE	:D		outcome of pre	nnancy				23d. Da	te of delive	ery
876 tificat ing phy	M/us	IF FEMALE: 23b. Was deceder past 12 mont		1 Live b	irth	2 [Fetal death	3 Ector	oic pregnancy	Mon	th	Day Year
Box 6876(e death certificate the attending phy:	Sicia	1 Yes 2			ant at time of o	death 5	Other (Sp	ecify)		· 1		
™ 5 € 5 1	Physician/M	Part II. Other sig	nificant condition			resulting i	in the underlyin	g cause given in f	Part I. 23e. D	id tobacco use o	contribute t	to the cause of death?
, P.O. ires that the signed by I be detached	Ş								1			obably 4 🗹 Unknown
ords, v require s been si should b	etec									Vas an 2 utopsy	4b. Were a prior to	autopsy findings available o completion of cause of
e law re has l	Completed								p	erformed? es 2 No	death?	
Division of Vital Records, tal or Attending Physician: The law requir is after death. **Al Director: After this certificate has been seled in by the funeral director, page 2 should!		25. Was case re	ferred to medical						th (Check only one)			
Vita ysicia gricci direct	To Be	examiner? 1 ✓ Yes	2 No	Hospital: 1	Inpatient 2			DOA Other				ner:
of ing Ph		27. Manner of De			of Injury n, Day,Year)	28b. Ti	ime of Injury	28c. Injury at Wo	1	ibe how injury o	ccurred	
sion trendi death. ctor:	atio	2 Accident	5 Pending Investig	otion	- of lations At	homo for	m street facto	ry, office building,	Table 1	on (Street and N	Number or	Rural Route Number, City
Jivisioi il or Attene after death I Director: d in by the	Certification:	3 Suicide	6 Could n	ot be		nome, iai	m, street, lacto	ry, office ballaing,		vn, State)		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ပီ	4 Homicid	Cartifying Phys	ician: To the he	st of my knowle	edge, deat	th occurred at t	he time, date and	place, and due to the	cause(s) and ma	anner as si	tated.
the H thin 24 the F	edical	(Check only one) 2		ner: On the basis	of examination	and/or in	vestigation, in i	my opinion, death	occurred at the time,	date and place,	and due to	tne cause(s)
5	₹	29b. Signature a	and title of certifier	and manner		·	2	9c. License numb	er			Month, Day, Year)
		Cler	de H	alla	rin			O.C.M.E.		Decem	ber 30,	
			ddress of person w	no completed cau	se of death (Ite	em 23a)	V Baltimore	Street Baltin	more, MD 21223			
		Carol Alla	an, MD Assis ——————————————————————————————————		egistrar's Sign		v. Dailliilliill					
S Regis	itate stra		JAN 132	011 2	MAA.		barker					
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10-UN

-09526 IK UNK		Please Type or Print in Black Indelib					
		Registrar	e of Death	_	Reg	g. No.	42754
Physic edical Exam					 Date of Death Month December 	Dav Year	3. Time of Death 0230 hrs
		Facility Name (if not institution, give street and number) 645 Knights Island Road	4b. City, Town, Earleville	or Location of Death		4c. County of Dear	th
Funera		Social Security Number		ear If Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY) 9. B	irthplace (State or Foreign
Director		213-98-8754 1∑M 2□F 29	Yrs. Months Da	ays Hours Min.	APRIL 2	22,1981 M	ountry) ARYLAND
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits
*	 	MD CECIL EARLI	EVILLE				1 Yes 2 No
Maryli r 28a-f ed at o	Director	10e. Street and Number	10f. Zip Code		100	g. Citizen of What Cou	untry?
vith the s 23a o e notifi	al D	PO BOX 51 11. Marital Status 12. Was Decedent Ever in U.S. 11:	2191 3. Was Decedent of F		ecify Yes or No-	USA 14. Race - Ame	rican Indian, Black,
death with the Maryland or items 23a or 28a-f shomust be notified at once.	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No		an, Mexican, Puerto I		White, etc.	, ,
rs after ural", o		3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Dec	1 Yes 2 X N cedent's Usual Occup		ork done	SpecifyHIT 16b. Kind of Business	
5 72 hou n "nati	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	ing most of working li			TOD. TURB OF BUSINESS	viridustry
5-0036 iled within 7 Hygiene.	фшо	12 17. Father's Name (First, Middle, Last)	PRINTE	R 18.Mother's Name	(Final Stindella Sta	PRINTING	COMPANY
21215-0036 Muld be filed within 72 hours after Muld by given water Hygie with marked other than "natural", event, the Medical Examiner.	BeC	EARL M. MARKEY, JR.			NNY STRE		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be positived at once.	မ					er, City or Town, Stat	e, Zip Code)
ages I and 2 shount of Health and Mr. If item 27 is not other traumatic		20a. Method of Disposition 20b. Place of D	WARREN R isposition (Name of c			20c. Location - City o	r Town, State
imor Pages ment of tant: If		T Durial 2 More mation 3 Nemoval from State	or other place) [C CREMATO	RY 1/1	5/2011	BALTIMORE	, MARYLAND
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		21. Signature of Funeral Service Licensee				ZEILER &	
Physician		23a. Fart Lenter the disease, or complications that caused the death. Do not en				MORE, MD 2 st, shock, or heart	Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. <u>Smoke And Soot Inl</u>	nalation W	ith Therma	al Injur	ies	Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):					
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause					
ed ssit	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):					
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760, icate be physical the buri	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date of deliver	1
Box 68760, c death certificate be ex the attending physician ed for use as the burial.	Physician/Medic	past 12 months?	Fetal death 3 Other (Specify)	Ectopic pregnan	icy	Month	Day Year
O. Bo t the deat by the at	Phys	Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in	the underlying cause	given in Part I	23e Did tob	acco use contribute to	the cause of death?
rds, P.O. requires that the been signed by hould be detach	þ		the disacriffing cade	giver in act.		2 No 3 ✔ Pro	
of Vital Records, ag Physician: The law require the tab retuined the this certificate has been simeral director, page 2 should b	Completed				24a. Was an autopsy	prior to	utopsy findings available completion of cause of
tal Reco	Som				perform 1 Yes 2		es 2 No
lital sician: is certif lirector,	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpa		Other Nursing		esidence 6 🗸 Othe	er Scene
n of V	n: To	27. Manner of Death 28a. Date of Injury (Month. Day Year) 28b. Time				w injury occurred	
Division tal or Attendir rs after death.	catio	Pending 2 X Accident Pending 12-11-10 fd 2:	30 am	Yes 2 X No		of house	
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be ex 4 hours after death. After this certificate has been signed by the attending physician rely filled in by the funeral director, page 2 should be detached for use as the burial	Certification:	3 Suicide 6 Could not be determined (Specify) house	street, factory, office	building, etc.	or Town, Sta Earlevil	te) 645 Knig LLe, Md.	ural Route Number, City hts Island R
hin the	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of one) 2 Medical Examiner: On the basis of examination and/or investigation.		date and place, and o	lue to the cause(s) and manner as sta	ted.
To with	Mec	and manner stated. 29b. Signature and title of certifier	29c. Licer	se number	- 1:	29d. Date signed (Mo	onth, Day, Year)
		J.M. 1t	O.C	.M.E.		December 12, 2	010
		30. Name and address of person who completed of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111	Penn Street, Ba	Itimore, MD 212	201		
		31 Date filed (Month, Day Year) 32 Registrar's Signature					

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Kendra Markey 10-09528

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	Certificat	te of Death	Reg. N	ło.	
Physici ledical Exam		1. Decedent's Name (First, Middle,Last) KENDRA K. MARK			2. Date of Death Month Da December 11	, 2010	3. Time of Death 0230 hrs
		4a. Facility Name (if not institution, give street an 645 Knights Road	d number)	4b. City, Town, or Location of De Earleville	eath	4c. County of Death Cecil	1
Funeral Director		5. Social Security Number 6. Sex UNKNOWN 1 M 2	7. Age (In yrs. last birthd		Min. JULY 12	Co	thplace (State or Foreign untry) ARYLAND
ow any		Usual Residence of Decedent 10a. State 10b. County MD CECIL	10c. City, Town or	Location EARLEVILLE			10d. Inside City Limits 1 Yes 2 X No
ith the Maryland 23a or 28a-f show notified at once.	irector	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Cou	ntry?
th with the ems 23a o t be notifi	Funeral Di		d Forces?	21919 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu		USA 14. Race - Amer White, etc.	ican Indian, Black,
s after deal ral", or it	by Fur	3 Widowed 4 Divorced If Yes, Giv. or Dates:	Year	1 Yes 2 No specify:	Lef work done	Specify: WH	ITE
215-0036 be filed within 72 hours after death with the Maryland mil Hygiens detter than "natural", or items 23a or 28a-fahe ent, the Medical Examiner must be notified at once	Completed			ring most of working life. DO NOT use			moust y
15-00% filed withi I Hygiene, ed other ti		0 17. Father's Name (First, Middle, Last) EARL MARKEY, III	<u>l</u>		ame (First, Middle, Maid	N/A en Surname)	
Ore, MD 21215-0036 set and 2 should be filed within 7 of set and 2 should be filed within 7 lifem 27 is marked of other than ther traumatic event, the Medica	To Be	19a. Informant's Name/Relationship (Type, Print PENNY MARKEY— GRANDMO		Mailing Address (Street and Number WARREN ROAD ESSE			e, Zip Code)
Fe, S and f Heal If item		20a. Method of Disposition 1 Burial 2 Cremation 3 Remove	20b. Place of I cremator	Disposition (Name of cemetery, y or other place)		c. Location - City or	
Baltimore, permit. Pages la Department of He Important: If ite injury or other ti	8	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	AILANI		CHARLES S.	ZEILER &	SON INC.
Physician /Medical xaminer		23a. Part I Enter the lisease, or complications the failure. List haly one cause on each line. Immediate Cause (Final disease a. Smok	e And Soot In		ac or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death
		Sequentially list conditions, if any, leading to immediate Due to (or	as a consequence of): as a consequence of):				
ed ssit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or	as a consequence of):				7
760, icate be executed physician and the burial - transit	Medical	d. X UNPENDED AMEND		-f per me g911 1-			
Box 68760, e death certificate be the attending physical for use as the bun	sician	23b. Was decedent pregnant in the past 12 months?	res, outcome of pregnancy ve birth 2 [regnant at time of death 5 [Fetal death 3 Ectopic pro		23d. Date of deliver Month	y Day Year
P.O. Be es that the de igned by the	1 0	Part II. Other significant conditions contribution		n the underlying cause given in Part I.			the cause of death?
cords, law requir has been s 2 should b	₽				24a. Was an autopsy	24b. Were au prior to death?	atopsy findings available completion of cause of
tal Rec cian: The certificate ector, page	Be Cor	25. Was case referred to medical examiner?		26.Place of Death (Ch			
	₽	1 Yes 2 No 28a. I		patient 3 DOA Other 1 No me of Injury 28c. Injury at Work?	ursing Home 5 Res		r: Scene
Division tal or Attendiants after death.	3	1 Natural 5 Pending 12	-11-10 fd 2	n, street, factory, office building, etc.	ATCTIM OF		ire Iral Route Number, City Shts Island
E 6 2 E	al Cert	4 Homicide determined (Spe 29a. Certifier 1 Certifying Physician: To the	best of my knowledge, death	n occurred at the time, date and place,	Earlevil and due to the cause(s)	e, Md.	ed.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the ba	asis of examination and/or inv ner stated.	estigation, in my opinion, death occurr		place, and due to the	
		9-M.	16	O.C.M.E.		ecember 12, 2	010
			edical Examiner 11	1 Penn Street, Baltimore, MD	21201		
S Regis	State strar	1/1/1/2/2014	2. Registrar's Signature	Kel			

Kandice Markey
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December 11, 2019 Good Name Country of December 11, 2019 Goo	Physicia		Decedent's Name (First, Midd	e,Last)					2	. Date of Dea	th	
Second Score of the Control of Co			KANDICE	K. MARKEY	Z					Decembe	r 11, 2010	0230 hrs
Social Social Picture Property Social Social Property Social Picture Property Social Social Property Social Picture Property Social P).		4a. Facility Name (if not institution	n, give street and n	ımber)	1	-	or Location	of Death			Death
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The state of the s	vsician		23a Part I. Enter the dise e, or	complications that of	aused the death	n. Do not enter th	ne mode of dyli	ng, such as o	cardiac or re	espiratory arr	est, shock, or heart	Approximate Interva
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me) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. December 12, 2010	leath certificate e attending phys for use as the b	ysiclan/Me	23b. Was decedent pregnant in the past 12 months?	1 Live I	oirth nant at time of de	2 Fe		3 Ectopi	c pregnanc	ey		
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 12, 2010	t the o		Part II. Other significant condit	ions contributing t	o death but not r	esulting in the u	nderlying caus	e given in Pa	art I.	23e. Did to	bacco use contribu	te to the cause of death?
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296. Signature and title of certifier O.C.M.E. December 12, 2010 30. Name and address of person/who completed cause of death (Item 23a)	the H tin 24 tin 24 tine F	Sa	(Check only 1 Certifying P	miner:On the basis	of examination a	and/or investigat	ion, in my opin	ion, death o	ccurred at t	he time, date	and place, and due	to the cause(s)
O.C.M.E. December 12, 2010 30. Name and address of person/who completed cause of death (Item 23a)	To t With COM	ed		and manner s	stated.	9						
30. Name and address of person/who completed cause of death (Item 23a)		2	Zab, Signature and title of centile	4	//							
			1	NN1. 1			0.0	J.IVI. ⊑.			December 12	<u>, 2010</u>
Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201			. /	who completed cau	se of death (Iten	,						
			Jack Titus MD. Der	outy Chief Medi	cal Examine	r 111 Per	in Street, B	altimore,	MD 212	01		

ORIGINAL

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Derartment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show an Intimor or After trainments and Indiana.	
1	Physici /Medio Examin	a e e
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Directors: After this certificate has been signed by the attending physician and completely filled in by the funeral director nange? should he detached for use as the burial-transit	

Funera Directo

	For State Registrar	State of	Maryland .		rtment of F			ental Hy	/giene Reg. No.	2010	4275
ian	1. Decedent's Name (First, Middle,	Last)	Robins	ion				2. Date of Domination		Year	3. Time of Death
ical iner	4a. Facility Name (If not institution, Manor Come	give street and numi			4b. City, Town, or	\sim			4c. (County of Deat	mal
-	220-14-0173	. Sex 7 1	'. Age (In yrs. last 85	t birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bi (Month D 4 – 28–	irth 2ay, Ye <i>ar)</i> 1925	9. Birt	hplace (State or Fore untry) VA
tor	Usual Residence of Decedent 10a. State 10b. County MD	na	10c. City, T	own or Loc							10d. Inside City Lim 1X Yes 2 □ N
al Director	10e. Street and Number 1737 N. Bond	Street			10f. Zip Code 2121	3			-	zen of What Co	untry?
To Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 □ Yes 2 If Yes, Give Year or Dat	es? ∰ No	!1	Vas Decedent of H f Yes, specify Cuba	lispanic Or an, Mexica Specify	n, Puerto P	cify Yes or N lican, etc.)		4. Race - Ame Black, White Specify:	
Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12th grade	Education grade completed) College (1-4		(Give I lifeE	lent's Usual Occup kind of work done o DO NOT use retired aborer	during mos	st of workin	g	T.	esting	-
To Be (17. Father's Name (First, Middle, La Howard Johns	•						(First, Middle Four	_		
-	19a. Informant's Name/Relationship Ethel Jackson	_			g Address <i>(Street</i> 4 Lasal				-	Town, State, 2	
	20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Spe	☐Removal from St	20b. Plac	e of Dispos etery, crem riso	sition (Name of natory or other plac n Fores	t t	1-10	nte -201]	20c. Loc Owi	ation - City or	
	21. Signature of Funeral Service Lie	censee	'		Name and Addre						21202
dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	r as a consequen	es of):	Dise	\ \S					
hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 Live bir	ome of pregnancy rth 2 ☐ Fetal de ant at time of deat wn	eath 3	Ectopic pregnanc	у			2	23d. Date of de Month	livery Day Year
by P	Part II. Other significant condition Hun-enden Sion	s contributing to dea	th but not resulting	ng in the un	nderlying cause giv	en in Part I	l.			se contribute to	o the cause of death
Completed	arter oscu	mosis	P P					24a. Wa auto per 1 □Yes	opsy formed?	prior to death?	utopsy findings availa completion of cause
Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	patient 2 ☐ ER	l/Outnatien	t 3 DOA Oth			(Check only		0 □Other (Spe	offy)
Certification: To	27. Manner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could no determine	28a. Date of (Month)	·	Bb. Time of Injury	28c. Injur Worl M 1 🗆]No	8d. Describe	how injury	y occurred d Number or R	ural Route Number,
IO.	29a. Certifier CertifyIng	Physician: To the b	sis of examination	edge, death n and/or inv	occurred at the tile vestigation, in my contract	me, date a opinion, de	and place, a	and due to the	e cause(s)	and manner a place, and due	s stated.
	one)	and manne									o to the cause(s)
Medical (29b. Signature and title of certifier		CRN	P	29c. Licens	e number	2.8		29d. Date	e signed (Mont	

DHMH 17 Rev 1/2

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10-09880 Jennifer Ruiz Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Deposition of Control Processing Control Processi			1- For State Certificate of Death Reg. No.													
Section for the control form of the control fo	Physici		Decedent's Name (First, Middle	,Last)						2			Ven			
Future Control of Co			Jennifer Ruiz								Decem	ber 22,	2010 Teal		1722 h	irs
Control Cont				, give street and nu	ımber)	4	b. City, Town	n, or Lo	cation of	Death		4	c. County o	f Death		
5 Section forceting Number Unit 6 Sec. 7 April to year last better filled 1				-			Baltimor	е								
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The state of the cause (s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number O.C.M.E. December 23, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Div	皇	deter) re	esidenc	e			1	orio Balti	more	. Md.	EIU	шап А	ve.
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Funeral				7. Age (In yrs. I	last birthday)	If Under 1		f Under 24l		te of Birth	(MM/DD/YYYY)		place (State or
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Box 68760 e death certificate be the attending physic of for use as the bu	hysician/Me	1 Yes 2 No 9 Unkn			eath 5 Oth	ner (Specify)				- 1	l		
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Divi	5	4 Homicide determ	mined (Specify)						1	JWII, GIGIC			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	(Check only 1 Certifying Phy	ysician: To the best niner:On the basis of										ause(s)
To with	₩ W	29b. Signature and title of certifier	and manner sta				ense num				9d. Date signed		
		D-M)_	-			0.1	C.M.E.				December 3		
		30. Name and address of person w	•										
		Donna M. Vincenti, MD			_		ore Stre	∍et, Balt	imore, M	D 2122	3		
S Regis	tate	31. Date filed (Month, Day Year)	32. Reg	gistrar's Signatu	parke	1							

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			State of Mary				lental Hyg	iene	010	10766
			State Registrar	Cen	tificate of E	Death	F	leg. No.	UIU	42/01
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				Date of Deat Month	h Day	Year	3. Time of Death
	Medic		Velovis Kunson				12	23	2010	6:54 PM
	Examin	er	4a. Facility Name (if not institution, give street and number) University of Maryland Medi	cal Center	Baltin	Location of Death		4c. Count	y of Death	
	Funeral		1 N 0 X	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)_	9. Birthpl Countr	ace (State or Foreign
	Director		218-58-5981 Usual Residence of Decedent	56 Yrs.			(Month, Day,	L <u>954</u>		MD
	how at			c. City, Town or Loc	ation				10	d. Inside City Limits
	anyla ta-f s iffed	ect	MD na	Baltim	ore					1 🔀 Yes 2 □ No
	or 28	盲	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Count	ry?
	with 1	eral	2500 Riggs Avenue		21216			USA		
	tems er m	ᇤ	11. Marital Status 12. Was Decedent Ever i	in U.S. 13. W	as Decedent of Hi	spanic Origin? (Spen, Mexican, Puerto	cify Yes or No-		ce - America	
ဖ္တ	fter d , or i	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give		Yes 2 No		nican, etc.)		.ck, White, et	
g	urs a tural' al Ex	Completed by Funeral Director	3 LAWIdowed 4 □ Divorced Year or Dates.					Specify	Blac	k
5	72 ho "nat	ed.	15. Decedent's Education (Specify only highest grade completed)	(Give k		ation Juring most of work	ing	16b. Kind of E	Business Inde	ustry
4	thin sne.	[등	Elementary/Seconday (0-12) College (1-4 or 5+)		NOT use retired) hier			Grocer	y St	ore
d 2	led with Hygier other t ent, th	Be (17. Father's Name (First, Middle, Last)	1 000		18. Mother's Nam	e (First, Middle, N	faiden Surnam	ne)	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ျ	Eddie Walston				Knight		,	
аī	s mai		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street a	nd Number or Rura	al Route Number,	City or Town,	State, Zjp Ço	ode)
Σ	d 2 sl alth a 1 27 i ertra		Latonia Walston/daughter	2500	Riggs	Ave. Ba	ltimor	e, MD	212	16
ore,	of He of He roth		20a. Method of Disposition 2 ☐ Removal from State 2	20b. Place of Dispos	ition (Name of atory or other place	e) !	Date	20c. Location	- City or Tov	vn, State
<u>Ĕ</u>	Page nent ant: I ury o		4 ☐ Donation 5 ☐ Other (Specify)			ery 1/6	/2011	Arbut	11c N	4D
ä	epartitical point of the control of		21. Signature of Funeral Service Licensee	22.	Name and Addres	s of Facility	4300 W	abash	Aven	ue
ш_	70 E 9 9		(Xder Ware		arch FF		Baltim		MD 2	1215
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not enter	the mode of dying	g, such as cardiac o	or respiratory arre	st,		Approximate Interval Between
	nysician		Immediate Cause (Final disease or condition	sinomia						Onset and Death
ment.	Medical Examiner		resulting in death) Due to (or as a cor	nsequence of):						
		ē	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying	пвесиляла сВ-					-	
	ed nsit	Ē	cause. Enter Underlying Cause (Disease or linjury	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
	xecur n and al-tra	Exa	that initiated events c. Due to (or as a cor	nsequence of):						_
09	ate be executed physician and the burial-transit	dical Examiner	L d							
376	ficate g phy as th		IF FEMALE:					-1		
œ œ	eath certificat e attending ph d for use as th	an/I	23b. Was decedent pregnant 23c. If yes, outcome of pr	regnancy Fetal death 3 🗆	Ectopic pregnanc	v		23d. Da	ate of deliver	у
B0	death he att ed for	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown		Other (specify)	,		Me	onth [Day Year
o.	at the		Part II. Other significant conditions contributing to death but no	ot resulting in the un	iderlying cause giv	on in Part I	One Did to		tribute to the	cause of death?
Division of Vital Records, P.O. Box 687	requires that the de been signed by the should be detached	d by		or robutang in the til	acity mg occaso giv	on in art is				ably 4 X Unknown
ğ	requi	ete					24a. Was a			sy findings available
ပ္ပ	e law thas I	Completed					autops perfori	y		pletion of cause of
m m	Physician: The law this certificate has al director, page 2 3		25, Was case referred to medical		06 DI	ace of Death (Check	1 Tyes	2 X No	1 Yes 2	2 🗌 No
<u>Ita</u>	sicia s certi	To Be	examiner?	2 ER/Outpatient	Otha	ır.	me 5 🗆 Reside	E	or (Cassiful	
of o	g Phy erthis eral c	e: I	27. Manner of Death 28a. Date of injury	28b. Time of	28c. Injury	at	28d. Describe ho			
o	ath. r: Aft	ical	2 Accident Investigation	ar) injury	M 1 □	? Yes 2□No				
/isi	r Atte ter de recto	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - building, etc. (Sp.	At home, farm, stree	et, factory, office		28f. Location (St. City or Town		er or Rural F	Route Number,
á	ital o urs af ral Di lled ir	alC				20				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	ledical	29a. Certifier (Check 2 Medical Examiner: On the basis of examiners)	nation and/or investig	gation, in my opinio	n, death occurred at	the time, date an	d place, and du	ie to the caus	se(s) and manner stated.
	o the vithin d o the ompl∉	ž	only one) 3 Certifying Nurse Practioner: To the best 29b. Signature and title of certifier	ot my knowledge, de	eath occurred at the 29c. License			cause(s) and m 9d. Date signe		
	⊢ ≯ F ŏ		N W- Clil MD			- 6271	_\	(1	123	2010
	,		30. Name and address of person who completed cause of death	(Item 23a) (Type. Pr		, VL 1	\	1	1 (7)	12010
			Damen Clark MD ZZ	5 GREE		Bala	LIMOLT	m D	21.	201
4	Stat		31. Date filed (Month, Day, Year) 32. Registrar's S		barker		, , ,	,		
	Registra	ar	JAN 12 2011 Been	v B. A	arke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 25,27,28a-f per me,g911,01/12/2011dhb Certificate of Death 1 - For State Registrar Reg. No 1. Decedent's Name (First, Middle, Last, 2 Date of Death Physician/ Month 1 20 AM mes Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 8. Date of Birth (Month, Day, Year) 4. 1954 If Under 24 Hrs. 9. Birthplace (State of Foreign 7. Age (In yrs. last birthday) If Under **Funeral** 1 ★ M 2 □ F Months Hours Min. Country)
Maryland Director 219-66-3885 56 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 ☐ Yes 2√☐ No MD St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21412 Great Mills Road 20653 USA be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? 1 Never Married 2 Married þ 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: white Completed 3 Widowed 4 X Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry unk (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 0 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည William Henry Russell Sr permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. Doris Juanita Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Nelson/sister 36728 Manor Road Chaptico, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ★ Other (Specify) in state rector Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ Tute Represtry
Due to (or as a consequence of): a Haute nknown disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner or Attending Physician: The law equires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last ORSTRUCTI and PAROVED BY MEDICAL E the burial-tran attending physician CERTIFICATION Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at Id be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Tes 2 No 3 Probably 4 Unknown Completed page 2 should een 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DISorder Snohosis has autopsy performed After this certificat 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) l B examiner? Other: 1 X Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Vursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) **Unknown** 5 Pending work Unknown M 2 🗶 No Unknown death 1 Tes ☐ Accident 6 Novestigation 6 Could not be completed filled in by the within 24 hours after deat To the Funeral Director: 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) **Maryland** determined Unknown Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3, Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day, Year) JAN 12 2011

Elizabeth Fryman, NP, Chesapeake Shores Nursing Home, Lexington Park, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene Amend Item 1 per dr.,g911,01/19/2011dhb

Certificate of Death

Reg. No. for State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Annie Simmons Month) 7:15 Physician/ М >TWWW/Y Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Monastery Ave. 214 S. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 □XE 02/14/1917 N. Carolina 93 Director 219-26-9054 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Director 1 🛚 Yes 2 🗆 No 28a-f Baltimore N/A MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9 23a Funeral U.S.A. 21229 214 S. Monastery Ave. permit. Page 1 and 2 should be filed within 72 hours after death vigeneration of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 X No ð Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3x Widowed 4 ☐ Divorced Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Housewife 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Annie Ruth Durham Samuel Dunn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 214 S. Monastery Ave., Baltimore, MD 21229 Rebecca McKnight(daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 01/04/11 4 Donation 5 Other (Specify) Arbutus Cem. Baltimore, MD Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21. Sign turn of Funeral Service Licenses 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition end Physician/ Sture Medical resulting in death) more thun Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (as a consequence of) Examir • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director. After this certificate has been signed by the attending nhysician and and -transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death signed by the a d be detached f Hnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ hrabidice 1 🗌 Yes 2 7 No 3 Probably 4 Unknown Completed should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed death? 2/ 1 ☐ Yes 2 ☐ No 1 🗆 Yes 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? ◆ Natural 5 Pending 2 🗌 No ☐ Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 26 434 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month athr 311 Z010 12:25 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death runsitions HealthCare SYKesville (orro) Funeral Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 M Months Days 0472971925 North Carolina Director 243-22-0011 Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location . Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** 10d. Inside City Limits MD Carroll Sykesville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7309 2nd Ave. 21784 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 1 Never Married 2 Married Black, White, etc. þ 1 Yes 2 X No Baltimore, Maryland 21215-0036 Hygiene. other than "natural", 1 ☐ Yes 2 😾 No Specify. 3 ₩ Widowed 4 Divorced Completed Specify.White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Child Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ဂ္ George Washington Croom Mary Elizabeth Wayne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Kathryn M. Frock/Daughter 71 Greenwood Lane, Aurora, WV 26705 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of I-Important: If ite any injury or ot 1 Purial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Wilmington National Cemetery 01/05/2011 Wilmington, NC 21. Signature of Funeral Service License Name and Address of Facility
Witzke Funeral Homes, Inc.
5555Twin Knolls Rd., Columbia. well MD 21045 23a. I art 1. Enter the disease, or complications that existed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Demention Medical Examiner BIKINSON Sequentially list conditions if any leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or iinjury that initiated events resulting in death) Last UP. Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t lirector, page 2 s autopsy performed Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iours after death.

Ieral Director: Ai

filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) W0059943 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

JAN 1 3 2011

32. Registrar's Signa

R- SUITE 307 VESTMINSTER MB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Marcus Gart Christi	an Trotman 1- For State	State of Mary	land / Depai	rtment of H	ealth and	Mental		g. No.	10 42764
Physician/	1. Decedent's Name (Fi	rst, Middle,Last)					2. Date of Deat	h	3. Time of Death
Medical Examiner	marcus Gart	Christan I	rotman	14. 6	ity. Town, or Lo		Month December	31, 2010 4c. County of	0610 hrs
		institution, give street and in	number)		ottingham	cation of Dea	atn	Baltimore	
Funeral	5. Social Security Numb		7. Age (In yrs. las			If Under 24	Irs. 8. Date of Birt		Birthplace (State or
Director	109-74-914			_	onths Days	Hours M	nin. Dec. 25		Foreign Country) New York
	Usual Residence of Dec		23	113.			DCC 23	,1507	
any		County	10c. City, 1	Town or Location					10d. Inside City Limits
nd show	Md.	Balto.		Not	tingham	1			1 Yes 2 X No
the Maryland a or 28a-f she tified at once	10e. Street and Number			10	f. Zip Code		10	og. Citizen of Wha	t Country?
th the Maryland 23a or 28a-f show notified at once. al Director	2 Dunhaven	P1. Apt. TC			21236			USA	
r death with or items 23 inust be no	11. Marital Status 1 V Never Married		ecedent Ever in U.S Forces?_		cedent of Hispa pecify Cuban, M		Specify Yes or No- rto Rican, etc.)	14. Race - White,	American Indian, Black, etc.
or ite	<u> </u>	1 Yes		1□ Va	2 X No s	oogifu:		Specify:	Black
ural"	45 December 10 Educati	Divorced If Yes, Give Y or Dates:		16a. Decedent's U			of work done	16b. Kind of Busi	ness/Industry
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5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	12		1	Manage	er			Sears Ap	pliance
Hygie Col	17. Father's Name (Firs	t, Middle, Last)	***		18.	Mother's Na	me (First, Middle, N	flaiden Surname)	
21215-0036 21215-0036 21	Keith O'Ne	il Trotman Relationship (Type, Print)		AON MARIES AN			Ve Simmo		Shale Zin Code)
D 21 should and Me 7 is mai		Neil Trotman	BRO.				Edgewood		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 27 is marked other than "matural", or items 23a or 28a-f aboundary or other traumatit event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	20a. Method of Disposit			lace of Disposition			Date		City or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		Cremation 3 Removal	ITOTI State	rematory or other p		1-	10-2011	Wheaton,	Md.
it. Partmen rtant	4 Donation 5 21. Signature of Funera	Other Specify:	Gat	e of Hear	ven Cem.	Facility	1 / 1 T		I a m a
Ba Perm Depa Impo	Luci			9705	Belair	Road	himunek l Nottingi	nam, Md.	¹ 21236
Physician		sease, or complications that	caused the death.	Do not enter the m	ode of dying, su	ch as cardia	c or respiratory arre	est, shock, or hear	t Approximate Interval Between Onset and
Medical	Immediate Cause (Fina	ne cause on each\ine. I disease	njuries						Death
Examiner	or condition resulting in		a consequence of)	:					
	Sequentially list condition		a consequence of)	١٠					
red nsit Examiner	cause. Enter Underlyin	g Cause	a consequence or,						
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60, te be e ysicia burial	IF FEMALE:		s, outcome of pregn	ancy				23d. Date of d	elivery
68760, certificate be nding physici se as the buritan/Med	23b. Was decedent preg past 12 months?			₂ Fetal d	eath 3	Ectopic pres	gnancy	Month	Day Year
Box 68760, e death certificate be the attending physicied for use as the burind hysician/Med	1 Yes 2 No 9		gnant at time of dea	other 5 Other	(Specify)				9
	Part II. Other significan	3 3 0 11	to death but not re	culting in the unde	lvina cause aive	n in Part I	23e Did to	bacco use contrib	ute to the cause of death?
Division of Vital Records, P.O. B ral or stending Physiciae: The law requires that the d rs after death. *I Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached errification: To Be Completed by Phyperial or the page 2 should be detached or the completed by Phyperial or the page 2 should be detached or the page 2 should be detached by Phyperial or the page 2 should be detached by Phyperial or the page 2 should be detached by Phyperial or the page 2 should be detached by Phyperial or the page 2 should be detached by Phyperial or the page 2 should be detached by Phyperial or the page 2 should be detached by Phyperial or the page 3 should be detached by Phyperial or the page 3 should be detached by Phyperial or the page 3 should be detached by Phyperial or the page 3 should be detached by Phyperial or the page 3 should be deatached by Phyperial or			to douth but her he		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1 Yes	2 ✔ No 3	Probably 4 Unknown
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of Viling Physical Company of the Co	1 ✓ Yes 2 27. Manner of Death	No 28a. Da	te of Injury	28b. Time of Injury	28c. Injury a	at Work?		now injury occurre	
on on ath.	1 Natural 5	reliaing	nth, Day Year) 1, 2010	0550 hrs	1 Yes	2 🗸 No	Pedestrian	s. Motor Veh	icie
Visi or Att frer de Direct in by	2 Accident 3 Suicide 6	Investigation 28e. PI	ace of Injury - At ho	me, farm, street, fa	ctory, office buil	ding, etc.	28f. Location (S or Town, S		or Rural Route Number, City
Division o Division of Attending nours after death. Interior: After after after death of the after and the after	4 Homicide		y) Major Road				WB 43 and W	alther Boulevan	d, Nottingham , MD
Division of Vital Rec To the Hospital or Attending Physiciae: The Within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page Medical Certification: To Be Con	29a. Certifier 1 Cer (Check only 2 Med	tifying Physician: To the b dical Examiner: On the basi	s of examination an	e, death occurred ad/or investigation,	at the time, date in my opinion, d	and place, a eath occurre	and due to the caused at the time, date	e(s) and manner a and place, and du	as stated. e to the cause(s)
N S S S S S S S S S S S S S S S S S S S	29b. Signature and title	and manne of certifier	stateu.		29c. License n	umber		29d. Date signed	(Month, Day, Year)
	Q	- M 1.			O.C.M.	E.		December 3	31, 2010
\hat{\lambda}		of person who completed							
	Jack Titus MD.				imore Street	t, Baltimo	re, MD 21223		
State Registrar	1 10 10 T 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Jay Year) Senewa 32.	Registrar's Signatur	Res					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 20190 4:30 Ам Virginia D. Unitus Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Annapolis Anne Arundel Genesis Spa Creek If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖺 F Months Hours Min. Septh, Pay Year 1926 Permsylvania Director 84 188-20-2438 Usual Besidence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Millersville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 732 Conoy Ct 21108 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 21 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White If Yes, Give 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) sales associate department store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Awenowicz Teofila Virginia Awenowicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah A. Unitus - daughter 732 Conoy Ct; Millersville, Maryland 21108 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1
Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☑ Donation 5 ☐ Other (Specify) Rona I 22. Name and Address of Facility State Anatomy Board Wad 655 W. Baltimore St; Baltimore, Maryland 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Onset and Death Immediate Sause (Final Physician 0 50:01 disease or con iti-resulting in death) h 1 Medical Due to (or as a consequence of) Examine U Mon Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes ∠ L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performe 1 Yes 2 No 2 2 25. Was case referred to medical examiner? B 26. Place of Death (Check only one) 2 WNo Hospital: Other: 잍 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner Ceath Certificate: 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 🗆 No 2 Accident
3 Suicide Investigation within 24 hours after deat To the Funeral Director; 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one) 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) 96 d address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Detouse

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#2 Per Phy G911 1/18/2011 III
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2010 Month Physician/ Woodard 7:35 PM evon 0 Medical 4b, City, Town, or Location of Death 4c. County of Death **Examiner** imar Medic 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Security Numbe Funeral Hours Country) Days 1.▼ M 2 □ F 63 **Director** 243-74-7634 Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland Director 1 X Yes 2 No Baltimore MD na 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 21215 4016 N. Rogers Avenue Apt USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ρ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) the llth Moving & Hauling self-employed event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theodore Woodard injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21208 7208 Chalkstone Drive Apt B3 Baltimore Gerod Woodard--son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) /12/11 Owings Mill, MD Garrison Forest 22. Name and Address of Facility Signature of fluneral Service Licensee March Funeral Home West any 21215 Avenue Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, skock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed lifled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a conse resulting in death) Last Medical P.O. Box 68760 IF FEMALE 23d. Date of delivery Physician/ 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗆 Yes 2 🗆 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 \(\sum \) Yes 2 \(\sum \) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA ျပ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending 2 🗌 No 1 Tes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) 1 T 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAKKOR rorge M. Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 558 A M David Earl Worsley 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Ralti more Kosedale ware Hos · ta Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Security Number 6. Sex 7. Age (In yrs. last birthday) 1 🛛 M 2 🗆 F 46 371871964 219-76-4422 Usual Residence of Decedent 10a. State 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2¾ No Baltimore Baltimore 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 21221 989 Honeywood Place Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give Black, White, etc. 1 Never Married 2 X Married 1 Yes 2x No Specify: Specify: Black 3 🗌 Widowed 4 🗌 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Grocery Store Stocker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jannie Colburn Edward Foster 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State Zip Code) 989 Honeywood Place Baltimore, MD 21221 19a. Informant's Name/Relationship (Type, Print) Veronica Worsley/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State Baltimore, MD 1/6/2011 King Memorial Pk 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22, Name and Address of Facility 4300 Wabash Avenue Baltimore, MD 212 al March FH West 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to wir as a consequence of: Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of ia 90 that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? hypertrophic 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an stentin autopsy

Physician Medical Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed

Physician/

Medical

Examiner

Funeral

Director

28a-f show

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23a

"natural", or items

is marked other than "natu aumatic event, the Medical

notified at

Examiner must be

Director

Funeral

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Completed

Be

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Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is

Baltimore, Maryland 21215-0036

Examine Physician/Medical þ Completed 24 hours after deatn.

Funeral Director: After this certificate has teleted filled in by the funeral director, page 2 s Be ည Certificate:

signed by the

Division of Vital Records, P.O. Box 68760

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 Yes 2 No
9 Unknown

ardio myopathy

6 Could not be

determined

performed? 1 X Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

_		
25.	. Was case referred to medic examiner? 1 ☐ Yes 2 ☑ No	cal
27.	Manner of Death	

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 5 Pending Investigation

Hospital

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

	29a. Certifier	
	(Check	
ı	only one)	

1 Natural

Accident

Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

RES0000

-3-2011

State

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANKLIN Square DR Balto md 21237 9000 Malik 32. Regis ar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 8120PM Decem Azariah Williams Jr. 30 20lb 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE HOSPITAL AGNES CAINT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 1 **⊠** M 2 □ F Months Days 8/31/1943 215-40-7652 66 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 □Yes 2 No Baltimore Halethorpe 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 30 Hummingbird Court 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2X Married Specify: Black 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Healtest Everning must be notified as once. Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

10a, State

MD

Director

Funeral

Funeral

Director

Physician /Medical Examiner

Physician: The law requires that the death certificate be executed physician and the burial-transi

P.O. Box 68760,

Records,

Vital of

Division

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certificate has been signed by the attending pricetor, page 2 should be detached for use as To the Hospital or Attending within 24 hours after death.

To the Funeral Director: completely filled in by the fi

3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1∟Yes 2M≥No	Specify:		Specify: Black
15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of working	16b.	Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire Plumber	ed)		Steam Trade
17. Father's Name (First, Middle, Las	t)		18. Mother's Name	(First, Middle, Maid	
Azariah Willi	ams, Sr.		Helena	Wilson	
19a. Informant's Name/Relationship Patricia Will		19b. Mailing Address (Stree 30 Hummingb			y or Town, State, Zip Code)
20a. Method of Disposition		I			Location - City or Town, State
1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Cont	_ Hemoval from State	lace of Disposition (Name of emetery, crematory or other plane) rrison Fore		ĺ	ings Mill, MD
21. Signature of Funeral Service Lice	nsee Saum	22. Name and Adda	4 F88-	rch Fune	eral Home West
23a. Part 1. Enter the disease, or conshick, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	nplications that caured the death one cause neach line. a. Due to (or as a consequence of the consequence	Do not enter the mode of dy	ing, such as cardiac o	or respiratory arrest,	Approximate Interval Between Onset and Death A SAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence)	ierice orj.	mali (ell LV	ng Cancer
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3 Ectopic pregnar	ісу		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resu	alting in the underlying cause g	iven in Part I.	23e. Did tobacc	co use contribute to the cause of death?
				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?				n (Check only one)	
1 Yes 2 No	Hospital: 1 Inpatient 2			me 5 🗆 Residence	e 6 ☐ Other (Specify)
27. Manner of Death 1	1	28b. Time of lnjury M 28c. Inj	ury at ork? □Yes 2 □No	28d. Describe how in	njury occurred
3 ☐ Suicide 6 ☐ Could not 6 determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory, office		28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
29a. Certifier 1 V Certifying F (Check only one) 1 Medical Example	Physician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, death occurred at the tion and/or investigation, in my	time, date and place, opinion, death occur	and due to the caus red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
001 01 1 1101 / 110		29c. Licer	nse number	29d.	Date signed (Month, Day, Year)
29b. Signature and title of certifier	enois m.				

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12/30 9:25 Boyd Younger Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care Nursing Baltimore Home 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Davs Hours Min 1 Month 8 Pay 1 9 46 Country) Director 64 230-58-8820 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Baltimore N/A 1 🖁 Yes 2 🗆 No MD 10f. Zip Cpd 15 10e. Street and Number ō 10g. Citizen of What Country? USA 23a Funeral 5203 Elmer Avenue and Mental Hygiene.

is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. Page 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. þ 1 Never Married 2 Married 2 X No Yes Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Black 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Factory Laborer 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden, Surname) Alameda Clarke ဂ Younger Willie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5203 Elmer Avenue Baltimore, MD 21215 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Marguerite Watson-sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State on-Site 1 Burial 2X Cremation 3 Removal from State 7/2011 Baltimore 4 Donation 5 Other (Specify) March FuneralHome-West Signatur of Funeral Service Licens 22. Name and Address of Facility 4300 Wabash Avenue Baltimore,MD 23a. Part 1. Enter the disease, or complications that sadsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dilure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death Ph sician/ disease or condition resulting in death) una ances Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 been signed by the attending should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregna ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy performe Hospital or Attending Physician: The this certificate Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 1 Yes 은 Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fi 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mule 47683 9/10 monu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mille 2835 Smith thre Smte

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

YOUNGER, BOUR

32. Registrar's Signature

203

Balmore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	tate of Maryland	Department of F		ntal Hygier		+2770	
\$	Physic		1. Decedent's Name (First, Middle, Last)	Allen			. Date of Death	Day Year	3. Time of Death	
	/Medi Exami Funeral Director		4a. Facility Name (If not institution, give street Gladys Spellman Spe 5. Social Security Number 6. Sex 579–52–9300	cialty Hospit	al Cheverl	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Yea	Prince Ge		
	the Maryland 28a-f show	ector	Usual Residence of Decedent 10a. State 10b. County MD Prince Geor 10e. Street and Number		own or Location r Marlboro 10f. Zip Code				10d. Inside City Limits 1 ☐ Yes 2 No	
after death with or Items 23a or minute was be or	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exportant: was be notified at	by Funeral Director	3908 Bishopmill Dr. 11. Marital Status 1 Never Married 2 Married	Vas Decedent Ever in U.S. Irmed Forces? Yes 2X No 1Yes, Give	20772 13. Was Decedent of H If Yes, specify Cuba		Citizen of What Country? JSA 14. Race - American Indian, Black, White, etc. Specify: Black			
21215-0036	ad within 72 hour gjene. er than "natural", the Med cal Ex.	Completed b	15. Decedent's Educatio (Specify only highest grade co.	rear or Dates: nppleted) College (1-4or 5+)	ia. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired Printer	ation during most of working		Specify: B Kind of Business/Ir Printing		
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Ms	To Be (17. Father's Name (First, Middle, Last) Raymond Allen				First, Middle, Maide line Hawl	en Sumame) Kins		
Baltimore, Mar	permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traum once.		19a. Informant's Name/Relationship (Type, Nathaniel K. Allen 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Remode 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Son 20b. Place cemei	3908 Bishopm of Disposition (Name of tery, crematory of Crematory 22. Name and Address	Date 12/24/	Upper Ma 20c 2010 Bal all Funer	arlboro, i Location · City or T ltimore, i cal Home	MD 20772 own, State	
8760,	Physician //Medical Examiner physician and physician and the pruial-transit	dical Examiner	23a. Page. Enter the disease, or complicatic shock, or heart failube. List only one call immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any learning immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	e of): 21/ure			MD 2071	Approximate Interval Between Onset and Death	
P.O. Box 68	the death certific y the attending p iched for use as	Physician/Medi	in the past 12 months?	yes, outcome of pregnancy □Live birth 2 □ Fetal deal □Pregnant at time of death □ Unknown	th 3 Ectopic pregnancy 5 Other (specify)			23d. Date of deliv Month	ery Day Year	
	v requires the been signed should be de	by	Part II. Other significant conditions contribu	ting to death but not resulting	in the underlying cause give	on in Part I.	1 🗆 Yes		oably 4.⊠Unknown	
Vital Records,	10 0	Be Completed	25. Was case referred to medical examiner?			26. Place of Death (C	24a. Was an autopsy performed? 1 Yes 2 N	prior to co	opsy findings available impletion of cause of	
o	ttending Phys death. ctor: After this / the funeral di	Certification; To	1 Anatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	a. Date of Injury (Month, Day Year) 28b.	Time of Injury 28c. Injury Work	4 Nursing Home 5 Residence 6 Other (Specify)				
ā	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	edical	29a. Certifier 1 Certifying Physician (Check only 2 Medical Examiner;	building, etc. (Specify) I: To the best of my knowledge on the basis of examination and manner stated.	ne ideath occurred at the time	e date and place and	City or Town, Sta	te)	totad	
ig W	To the within 2 To the complet	W	29b. Signature and title of certifier Humer My 30. Name and address of person who comple	ed early (Item 23a)	29c. License	9556	13	ate signed (Month,	Day, Year)	
	Sta Registra	-	TIMPY Mujah 31. Date filed (Month, Day, Year) DEC 282010	d M.D. 32. Registrar's Signature	6130 Landover	Rd., Cheve	dy, MD	20784		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ror State RegistramEND#19aperINF1/12/11, BMW, McGertificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 9 Physician/ DECEMBER CATHERINE MARIE ANSELMO 2010 10:00P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth Days Hours (Month, Day, Year) 1 🗆 M 2 🕱 578-30-0892 **Director** Sept 83 1927 \mathbf{D} Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Frederick 1 Yes 2 v No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4397 Early Road 21704 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify: "natural". Completed 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Editor Dept. of Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked ot 0 Reuben Henry Heflin Etta Gertrude Stommel 19a Informant's Name/Relationship (Type, Print) Marchele, Anselmo, Paluchak Marchele, Anselmo, Valughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trat 2631 Bridgewater Cove, Wilmington, NC 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 cemetery, crematory or other place)
Gate of Heaven
Cemetery 1X Burial Cremation 3 Removal from State Silver Spring, M D Other (Specify) 5 🗔 Francis J. Collins Funeral Home 00 University Blvd. W., Silver Spring, MD 23a. Part 1. Enter the lisease, or complications that caused the highth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ pheumoni disease or condition resulting in death) Medical Due to (or as a consequence of Examiner idn Sequentially list conditions. if any, leading to Immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): resulting in death) Last physician the buria Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? ò Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No Yes Be 25. Was case referred to medical director 26. Place of Death (Check only one) examiner? 2 X No Other: ဂ္ဂ 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral director director director director director. 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier ec. 30, 2010 MOD 35106 30. Name and accress of person who completed cause of death (Item 23a) (Type, Print) Myuna Hee
31. Date led (Month, Day, Year) 744 400 Frederick, MD

DHMH 17 Rev 7/2009

State

Registrar

JAN 03 2011

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vear Augustine Eleanor Helen Medical December 2010 0:30 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5550 Tuckerman Lane, Apt. 418 North Bethesda Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Days Hours 0671971920 New York Director 125 09 9324 90 Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery North Bethesda 1 Yes 2 No 10e. Street and Number 6 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be with 23a Funeral 5550 Tuckerman Lane, Apt. 418 20852 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced "natural" Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, <u>the Me</u> Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Augustine Camille Vodola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thad Ficarra/Nephew 10815 Brewer House Rd. North Bethesda, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place 01/04/2011 Long Island, NY 4 ☐ Donation 5 ☐ Other (Specify) Calvary Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Lung Cancer Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Hypertension Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): The law requires that the death certificate be executed Arteriosclerosic Heart Disease Cause (Disease or iinjury that initiated events resulting in death) Last as the burial-t Due to (or as a consequence of). signed by the attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ò 5 Other (specify) Month Day Year Pregnant at time of death be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 Yes 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No certificate 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Hospital: ပ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at hin 24 hours after death.

the Funeral Director: After appleted filled in by the funeral 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital c 24 hours a within 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

State

29b. Signature and title of certific

Ajay Reddy MD

JAN US ZUIT

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3200 Tower Oaks Blvd.,#110

32. Registrar's Signature

29c. License number

Rockville, MD

D53691

29d. Date signed (Month, Day, Year)

12/28/2010

20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ P_{M} December 26, 2010 2:00 Katherine May Bradley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 16010 Excalibur Road Bowie If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 🛣 F Days June 8, 1924 Months Hours Min. Vermont Director 86 009-14-7551 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Prince George's Bowie Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 16010 Excalibur Road 20716 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education Prince George's (Specify only highest grade completed) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Board of Education Accountant Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ၀ Harold H. Dowlin Katherine Keenan permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Bradley/ Son 4019 Chelmont Lane Bowie, MD 20715 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cernglery, crematory, or other place)
Maryland
Veterans Cemetery 20c. Location - City or Town, State any injury or 4 Donation 5 Other (Specify) 1/10/2011 Cheltenham, MD 21. Signature of Tuneral Service License 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Pulmonary Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last ending physician a use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year completed filled in by the funeral director, page 2 should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Astuma Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Hyperten sion 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Wellin's Type II performed Dinbetes 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 N Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗆 No 1 Natural 5 Pending Investigation Accident 24 hours after deat Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. only one) 29b. Signature and title of certifier 29c. License number D45235 Bright Mu

タル State Registrar

DHMH 17 Rev 7/2009

BIUD# 203, DUNKING, MD 80754,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

10845 Town Center

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 23 2010 10:30A M Gene Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Genesis Elder Care Spa Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 🕅 M 2 🗆 F Hours F(PB), P4y, Y2 931 Marry land 79 Director 214-26-0568 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with USA 130 Hearne Rd. Apt 509 21401 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: **Black** "natural", 3 Widowed 4X Divorced Year or Dates Mental Hygiene. larked other than "natur latic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation Anne Arundel Co. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Board of Education 0 Bus Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ပု James R. Brown Mazie Griffin and i 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2111719a. Informant's Name/Relationship (Type, Print) Page 1 and 2 sl ment of Health a 4065 Springwater Ct. Apt K Owings Mills, Cynthia Pugh-Givens(Niece) 20b. Make of Dispetitory (Mannayof 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State 12-28-10 Arnold, Md. 4 Donation 5 Other (Specify) U.M. Church 2W Marme a Rease Fability Sons Mortuary, P.A. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 9 Unknown P.O. I à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Division of Vital Records, 1 Yes 2 No 3 Probably 4 Usenown icate has been sig ; page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No After this certificate 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Dursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After thi filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) **⊠**atural 5 Pending 2 🗌 No death. 1 Yes Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after or To the Funeral Direct determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier сопретен Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in rity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signaturé and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 23 D53111 2010 Win 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 ANNADUIS, MO COLONI 31. Date filed (Mont 32 Benistrar's Signatur State 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Decem Day Physician/ Year 2010 ber 23 01 Ida JOEANN Denson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner albot stoh Memorial Hospi a 8. Date of Birth (Month, Day, Social Security Number last birthday If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Min. Hours 42-5 1 □ M 2 □**V**F Months **Director** Yrs Mary Usual Residence of Decedent items 23a or 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No 00 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 60 . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married ō þ 2 No ☐ Yes Maryland 21215-0036 1 Yes 2 No If Yes, Give Iack ZZX "natural", 3 ☐ Widowed 4 ☑ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than, Elementary/Seconday (0-12) College (1-4 or 5+) is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental ည tchett arence sen eva 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is + 6 a injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility
HENYY FUNEY
5 10 Washir 21. Signature of Funeral Service Licenses eral HOME any 161 23a. Pour . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final 08 Physician/ uncontrolled hypertension Complications disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner complications UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) physician s the burial Physician/Medical P.O. Box 68760 use as IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No ō Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 s certificate has 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 🔀 No မ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury work? **Natural** 5 Pending 24 hours after death. Funeral Director: A 2 No Accident Investigation 6 Could not be Suicide within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and 29d. Date signed (Month, Day, Year) 488 201 RΟ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) md Bhoming 21632 derals Dung da 31. Date filed (Month, Day (Month, Day, Year, Registrar's Signature State Registrar

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1	ary	z should be fined within /2 hours after death with the Maryland that d Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (19b. Mail	ina Addr	ess (Street a			er City	or Town State	Zin Code)		
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64	Box 6	attendi for use	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o	l 🗌 Feta	Ideath 3[Ectopi	c pregnancy	/			23d. Date of delivery			
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	W W	8		30. Name and address of person who o	completed cause of dea	th (Item :	23a) (Type, F	rint)	DIV (SIO	number 1044 V Shell	SAUS	BUA	4 MD 21	150 4		
		State Registra	~	11. Date filed (Month, Day, Year) JAN 0 3 2	32. Registrar's	s Signatu	re A	ark	1			-		,		
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARINA **BECKER** DECEMBER 24 2010 AVA1:02 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ST. MARY'S 24658 GREENVIEW DRIVE HOLLYWOOD 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Days Months Hours Min. Director MAY 26 Y1947 SOUTH CAROLINA 578-64-3142 63 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1X Yes 2 ☐ No MD ST. MARY'S LEONARDTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22380 ENOCH ROAD 20650 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Health and Mental Hygiene. tem 27 is marked other than "natural", 1 ☐ Yes 2 X No Specify: BLACK 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ MOSES ROBINSON MARY LEE HAYWOOD permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24658 GREENVIEW DRIVE HOLLYWOOD, MARYLAND 20636 KAREN RODRIGUEZ/DGT 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) RIVERDALE CREMATORY 1/8/11 RIVERDALE, MARYLAND J. B.JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ BREAST METASTATEC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 X No Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?
Yes 2X No 2 🗶 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? DGT. မ 2 No Other: HOUSE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 XOthe 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 \(\sime\) Yes 1 24 hours after death.

le Funeral Director: A pleted filled in by the fu Accident 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar (Check

30. Name and ad-

Μ 31. Date filed (Month, Day, Year)

AMIR

only one 29b. Signature and title of

ress of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

M.D.

KHAN

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

68844

29d. Date signed (Month, Day, Year)

20650

291 2010

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

25500 POINT LOOKOUT ROAD LEONARDTOWN, MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day BEASON VIOLA DECEMBER 30 2010 2:59AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death CLINTON 4c. County of Death
PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔻 Days Min SOUTH CAROLINA Director 250-42-2791 T919 Usual Residence of Decedent or 28a-f show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shoraumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director PRINCE GEORGE S BOWIE 1 H Yes 2 □ No MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20716 USA 16010 EXCALIBUR ROAD #203 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc <u>გ</u> 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOUSEWIFE PRIVATE Be permit. Page 1 and 2 should be filed be Department of Health and Mental Hyg Important; If item 27 is marked othan any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARTHA DODD **JACKSON** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16010 EXCALIBUR ROAD #203 BOWIE, MARYLAND 20716 IRENE RANDELL/DGT. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 E Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 1/7/11 CLINTON, MARYLAND ignature of Functor (rvice Li 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events. Examine signed by the attending physician and detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 month Pregnant at time of death Unknown Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed eral Director: After this certificate I filled in by the funeral director, page 2 🔀 No 1 Tes 25. Was case referred to medical To Be 26. Place of Death (Check only one) Hospital 1 Tyes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne f Death Certificate: Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Natural 5 Pending injury Accident Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Ex miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 20/0

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month Charlie J. Clement 3:000 M Decamber Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore-Washington Medical Center Glen Burnie 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Days Hours May 129 y, 1935 Terriessee Director 411-50-4200 75 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Sant If item 27 is marked other than "natural", or items 23a or 28a-f shour or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Crofton 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1781 Shaftsbury Ave. 21114 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🖾 No Specify: Specify: White Completed 3 Widowed 4 ☐ Divorced 1954-57 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Truck Driver Gasoline & Oil Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Nathan Clement Willie Ruby Bunch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James H. Clement / Son 1781 Shaftsbury Ave., Crofton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of I Important: If ite any injury or ot 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 12/28/2010 Baltimore, MD 21. Signature of Funeral service to nsee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to or as a consequence of): Examiner Seque tially list or dilione, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence that the death certificate be executed attending physician and I for use as the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year / the & Unknown 9 Unknown signed by tl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy Hospital or Attending Physician: The certificate ☐ Yes 2 N No 1 Yes Division of Vital funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Other: ၉ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature. and litle of certifie 29d. Date signed (Morath, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ December Margaret Joan Cable 23, 2010 8:39 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Bowie Health Care Center Bowie . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours 08/19/1937 **Director** 316-36-4876 73 Indiana Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Maryland Bowie 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12813 Chesney Lane 20715 U. S. A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 72 hours after Yes 2 🔀 No Baltimore, Maryland 21215-0036 and Mental Hygiene.
is marked other than "natural", If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: White 3 X Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F 2 John William Beach Louella Beulah Jones 19a. Informant's Name/Relationship (Type, Print)
Brian Cable/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 13308 Littlepage Place, Bowie, Maryland 20715 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Atlantic Crematory 1 Burial 2 K Cremation 3 Removal from State 12/24/2010 Glen Burnie, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home, 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition 0 Medical resulting in death) Due to (or s a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to in medicause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Month Year 1 ☐ Yes 2 € 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 And 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy performed' 1 Yes 2 No 25. Was case referred to medical examiner? Be completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 / No 1 Tes Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner Teath 28b. Time of 28c. Injury at work? injury ▶ Natural 5 Pending 124 hours after death e Funeral Director: A 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifie 2 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew S. Dobin, M.D., 4175 North Hanson Court, Suite 203A, Bowie, Maryland 20716

State Registrar 31. Date filed (Month, Day, Year)

DEC 2 8 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#17, 18, 2018 State AACO HEALIH DEPT. 1/3/2011 CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Luciana Α. Cruda December Дм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Min June 25, 1930 Phorniy ppines Director 517-19-5923 Usual Residence of Decedent fshow 10a. State filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 X No Calvert 0wings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2344 5th Street 20736 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces 1 1 Yes 2 No \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 X Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Homemaker Own Home t. Page 1 and 2 should be filed with thrent of Health and Mental Hygien trant: If item 27 is marked other t njury or other traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname)
Natividad
Natividad 17. Father's Name (First, Middle, Last) Patalino Alforque Catalino Alforque Repunte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4919 Beech Street Shady Side, MD 20764 Anna Fagan/ Granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/5/2011 **Philippines** 21. Signature of Funeral Service Li 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between PNEUMONIA Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the sompleted filled in by the funeral director, page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Division of Vital Records, Completed 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 X No 2 1 Yes 1 Ninpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, (Check only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0061219 12:27.2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL 301 HOSPITAL DR GLENBURNIE HARVINDER SINGH ARORA BWMC

State Registrar 31. Date filed (Month, Day, Year)
DEC 2 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Examiner 4b. City, Town, or Location of Death Birthplace (State or Foreign Country) 8. Date of Birtl **Funeral** Months Director "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Anne Arundel Annapolis 1X Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21403 USA 35 Milkshake Lane 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc 1 X Never Married 2 Married δ 1 ☐ Yes 2X No White If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify Completed 3 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Paralegal Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental I tem 27 is marked o John Gerard Clancy Edna Lyons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 332 Derbyshire Lane, Riva, MD 21140 Martin Clancy / Brother Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 28 Department of metro Crematory or other place) 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) = 6 Baltimore, MD 2010 22. Name and Address of Facility CREMATION DIRECT 495 Ritchie Hwy, Severna Park, MD 21146 23a. art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine death certificate be executed Cause (Disease or iinjury that initiated events After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death Dav 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? Yes 2 No death? Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital ၉ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) nours after death.

neral Director: After the filled in by the funeral. 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 \square No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature R13510le

(Item 23a) (Type, Print) Colony Dr. Nanapol

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

Records,

Division of Vital

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Connell 12 23 235/A M trances Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death The bardens 04 William 1411 Talbot Aston Manor 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 🗆 M 2 🕞 (Month, Day, Year, Months 223.36.6146 Director Virginia Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Caroline MD Preston 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21655 U.S.A. 21821 Water Street P.O. Box 66 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No White 3 🖪 Widowed 4 🗆 Divorced Completed Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Fairfax County Circuit Elementary/Seconday (0-12) College (1-4 or 5+) 12 Chief Deputy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Burns Thomas Archie Douglas Donohoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3909 Tavistock Drive, Hurlock, MD 21643 Sharon Mills, Niece permit. Page 1 and 2 Department of Health Important: If item 2' any injury or other tonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ★ Burial 2 Cremation 3 ★ Removal from State Fairfax City Cem. 01/03/2011 Fairfax, Virginia 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 700 Locust Street, Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Encl-stage

Due to (or as a consequence of): disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Dav Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cerebro Vascular 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy • Hospital or Attending Physician: The 24 hours after death.
• Funeral Director: After this certificate by performed' 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Hother (Specify) ASST Living 1 ☐ Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the basis of my incomed at the time, date and place, and due to the cause(s) and manner stated. (Check only onei id at this time, data and plane, and due to the e 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) L. Shim CIENP R077623 12-23-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501 Dutchmen's Lame Easton MD 21601 CRIVP Krystal L Thomas

State

Registrar

31. Date filed (Month, Day, Year)

SO MAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink2Ensura All Copies Are Legible.
Amend 29d per med cert elible Ink2Ensura All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Virginia L. Clark Dec 2010 6:00a 31 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Elkton Care and Rehab Elkton Cecil If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 🗓 F 222-28-2696 87 21 1923 WV Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 □Yes 2 No Directo MD Cecil E1kton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2245 Old Field Point Rd. 21921 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ X lo If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Mar Iland 21215-0036 1 □ Yes 2 □ No Specify. þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dock Ellis ဂ္ Ora Roach 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Clark/Daughter in Law item 27 other to 2245 Old Field Point Rd. Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ō permit. Page Department o Important: if any injury or once. **≔** 5 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1/4/2011 Gracelawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) New Castle, DE 22. Name and Address of Facility R.T. Foard and Jones, Inc. 122 West main St. Newark, DE 19711 21. Signature of Fun ral Service 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician CHRONIC FAILURB RENAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) this certificate has been signed by the a director, page 2 should be detached to 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No i or Attending Physician: after death.
Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) b. N. Nonce N DO065733 December 31, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NARMANA RA V. PULA, 126 A EMIT STREET, FLKTON MD -21921 ITIGH 31. Date filed (Month, Day, Year) 82. Registrar's Signature State JAN 04 2011 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Esther M. Cannon December 28, 2010 7:10 p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Brooke Grove Nursing Home Sandy Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Mar. 8, 15 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 25 □ F ountry) DC 577-24-6798 88 Yrs. 1922 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r then "neturel", or Itema 23a or 28a-f ehow the Medical Examinar must be notified at 10d. Inside City Limits X Yes 2 No Director MD P.G. Hyattsville 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 2305 Erskine Street 20783 USA Funerai filed within 72 hours after death Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Specify: Completed by 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If item 27 is marked otheny injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edgar Menefee Mary Stewart Wingfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John R. McCleaf, Jr./Son-in-law 5217 Kalmia Drive, Dayton, MD 21036 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ₺ Burial 2 Cremation 3 Removal from State Dec. 31, 4 □ Donation 5 □ Other (Specify) 🗫 Louis Cemetery 2010 Clarksville, MD 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Sopvice acensee 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** VASCULAR ENDSTAGE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the ettending physicien and hed for use as the burlal-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant al time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 🗌 Yes 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2X No or Attending Physician: After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation To the north within 24 hours after death.

ATO the Funeral Director: After the funeral new the fur 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DECEMBER 29, 2010 death (Item 23a) (Type, Print) HOWE WILLIAMSPORT 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 0 3 201 Registrar

DHMH 17 Rev 1/2001

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Division of Vital Records, P.O. Box 68760,	al or Attending Physician: The law requires that the death certificate be executed a than death	I Director: After this certificate has been signed by the attending physician and
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AN withir the comp	Me	29b. Signature and	title of certifier	Ook	2		29c. Licens	e number		9d. Date signed (Mon	th, Day, Year) - 26, 2010	
		30. Name and addr		completed cause of d	leath (Item	23a) (Type,		tre Gai				
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			State of Maryland / Dep	artment of Health and N rtificate of Death	Mental Hygier	2011	1,2787		
			Registrar 1. Decedent's Name (First, Middle, Last)	tinoato o Double	2. Date of Death		3. Time of Death		
	Physicia		Jane Short Cassidy		December	28, 2010	12:12 рм		
	Medic Examin		4a. Facility Name (if not institution, give street and number) 28637 Old Pasture Drive	4b. City, Town, or Location of Death Easton		4c. County of Death			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birth	nplace (State or Foreign intry) D • C •		
	Director		579-24-8544 1 □ M 2 ☑ F 87 Yrs. Usual Residence of Decedent		Aug. 5, 1	923	"D.C.		
	at at	ō	10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits		
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	with the N 23a or 2 Ist be no	eral Di	10e. Street and Number 28637 Old Pasture Drive		Citizen of What Cou SA	untry?			
0000	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The permanent: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 Married 13. Widowed 4 □ Divorced 14. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 Married 15. Was Decedent Ever in U.S. Armed Forces? 16. Yes 2 Married Forces?	14. Race - Amer Black, White Specify: Whit	, etc.				
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	5		Marge Krud-Honson Ch	R0771	70 /	12/28	110		
			30. Name and address of person who completed cause of death (Item 23a) (Type, Carol Knud-Hansen, CRNP 8579 Comm	Print) erce Drive, Easton	n, MD 2160	1			
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21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at the Medical Examiner must be notified at		Elementary/Sec 12	onday (0-12)	College (1-4 or 5	i+)	l	DO NOT u					0	wn Home			
ď	filed val Hyg		17. Father's Name ((First, Middle, Last)			1	<u>Jincina</u>		18. Mot	her's Name	(First, Middle			•		
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Maryland	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at			ame/Relationship (7)			1	-						or Town, State, Zip Code)			
	and 2 s Health tem 27 i		VIVIAN L 20a. Method of Disp	. Cavalie	eri / Daug	20b. P	lace of Dis	osition (Na	ame of					C 20015 Location - City		vn. State	
F28 F Baltimore,	permit. Page 1 and Department of Important: If ite any injury or ot once.		1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State										•				
alti	permit. F Departm Importa any inju once,		4 Donation 5 Other (Specify) National Crematory 101/03/11 Falls Chur 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons												V.A.		
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					plications that caused one cause on each line	the death	n. Do not ei	nter the mo	de of dying	, such a	s cardiac or	respiratory ar	rrest,			Approximate Interval Betwee	
1	Ph_sician/ Medical		Immediate Cause (disease or condition resulting in death)		a. Brain										+	Onset and Deat	n ——
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	rificate be executed ing physician and as the burial-tracel	by Physician/Medical Examiner	resulting in death) I	Last	Due to (or as a	a consequ	ierice oi).					KU.					
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7 6	death certific	an/N	IF FEMALE: 23b. Was decedent		23c. If yes, outcome 1 Live Birth	of pregnar	ncy Ldeath 3	Ectopic	: neopancy			.5 3c	1	23d. Date of	deliver	у	
(अ Box	the att	/sici	in the past 12 r 1 ☐ Yes 2 x 9 ☐ Unknown	∑ No	4 Pregnant at 9 Unknown	t time of d	leath 5	Other (specify)					Month	[Day Year	
P.O.	that the	/ Ph			ontributing to death b	ut not resu	ulting in the	underlying	g cause give	en in Par	t I.	23e. Did t	obacco	use contribute	to the	cause of death	?
44 5	uires ti	q pe										1 🗆	Yes :	2 🕱 No 3 🗆	Proba	ably 4 🗆 Unki	nown
JUND € Records,	w requise been 2 shou	plet										24a. Was		24b. Were	autops	sy findings availa	able
∃ Red ∃	The law requires ate has been sigi page 2 should be	Completed		-								auto perfo	ormed?	death	1?	P⊠ No	101
l Vital	ician: Sertific ector,	Be	25. Was case referre examiner?		Hospital:						ath (Check	only one)	ৃ			7081	
of <	Physic rthis c	٦.	1 X Yes 2 No No Nursing Home 5 Residence 6 Other (Specific										ecify)				
ج لك	nding ath. ; After e fune	27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? 2 XAccident Investigation 3 Suicide 4 Homicide Homicide 28a. Date of injury 28b. Time of injury 1 Work? 12/7/10 28b. Time of injury at work? 12/7/10 28b. Time of injury at work? 14/05 M 1 Yes 2 X No Fall 28d. Describe how injury occurred Fall 28d. Describe how injury occurred Fall 28d. Describe how injury occurred Fall															
ALIE Division	r Atte ter de recto	ertif	3 Suicide 4 Homicide	6 Could not b determined	e 28e. Place of Inju			treet, facto	ry, office		2	8f. Location (Street a	and Number or	Rural F	Route Number, consin A vy Chase	1770
AVALI Divisio	Hospital or Attending Physician: 44 hours after death. Funeral Director, After this certific sted filled in by the funeral director.				Assist	ted L	iving	Faci	ility								,MD
X	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director After this certificate has been signed by the attendin completed filled in by the funeral director, page 2 should be detached for use	Medical	(Check 2	Medical Exami	sician: To the best of iner: On the basis of ex se Practioner: To the l	kamination	and/or inve	estigation, in	n my opinion	i, death	occurred at t	he time, date a	and plac	ce, and due to the	ne caus	e(s) and manner	stated.
S	To the To the Comple	2	29b. Signature and		1 11	Sout Of Thy	A		c. License i	number		,		ate signed (Mo	nth, Da	ay, Year)	
	4		> L	on A	hields	, M	4		6	8	374	F		12/2	-8	10	
			V	111	Shiel	eath (Item	23a) (Type,	Print)	V				R-	12/2	/	m N	
	State	e	31. Date filed (Monti		32. Registra		ure	AS.	<u> </u>					חכשמ	41		
	Registra	r		13 / 1/3	A second	100	Sale.	2									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:30 am Coplon December Rose 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Brooke Grove Assisted Living Sandy Spring 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7, Age (In vrs. last birthday) **Funeral** Country) Maryland 1 □ M 2 🛛 F Months Days Min. Director 213-09-7468 98 Usual Residence of Decedent 28a-f show ıral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Montgomery Olneu 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1612 Hickory Knoll Road 20830 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. "natural", 3 X Widowed 4 □ Divorced Specify: Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Communications Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isaac Strauss Ida Rodman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bari C. Attis - Daughter 2375 NW 29th Road. Boca Raton, Florida 33431 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 🗵 Burial 2 🗆 Cremation 3 🟝 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem Grdns | 12/30/2010 | Falls Church, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 1 Year shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Arteriosclerotic Cardiovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Jequentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that in the cause that in the cause of Examine Due to (or as a consequence of): Transit Land the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 👿 No
9 ☐ Unknown Dav Month sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Alzheimer's Disease 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? in 24 hours after death.

the Funeral Director: After this certificate Inpleted filled in by the funeral director, page 2 X N Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted Other: 4 Nursing Home 5 Residence 6 🗶 Other (Specify) 2 X No ျှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate; 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Within 24 hours a
To the Funeral Medical 29a, Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

an anyon My

A. Rossi.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D..

ρ

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D24543

3305 N. Leisure World Blvd., Silver Spring, Maryland 20906

29d. Date signed (Month, Day, Year)

December 29, 2010

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		for State Registrar		nate of t	viai yiai		tificate			vicitaiiiy	Reg. No	2010)	42790
Physicia		Decedent's Name (First, M Anth		Culler	-Sant	iago				2. Date of De Month Decemb	ath Day	/ Yea	r n	3. Time of Death 9:40 A.M
Medic Examin		4a. Facility Name (if not institu					4b. City, To	wn, or L	ocation of Death	•		County of De		<u></u>
,		18618 Nathan							mery Vil			Montgo		
Funeral Director		5. Social Security Number 212-87-9582		2 □ F 7. A	ige (in yrs. i	ast birthday) Yrs.	If Under 1 Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Dec 4	th y, Ye <i>ar</i>) • 20	09	Birthpla Bou <i>ntr</i> y	ace (State or Foreign y) Maryland
nd how at	r	Usual Residence of Decedent 10a. State 10b. Cou			10c. Cit	ty, Town or Loc	ation						-	d. Inside City Limits
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r deat or iter niner	by Fu	11. Marital Status1 X Never Married 2 □		Was Deceden Armed Forces 1 🔲 Yes 2 [?		Vas Deceder Yes, specify	nt of Hisp / Cuban,	panic Ori <mark>gi</mark> n? (Sp , Mexican, Puerto	oecify Yes or No- o Rican, etc.) 14. Race - American Inc Black, White, etc.				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		3 Widowed 4 Divo		If Yes, Give Year or Dates.	∆ NO	1	☐ Yes 2	₩ No	Specify:			Specify:	Whi	Lte
72 hou	Completed		edent's Educat nighest grade c			(Give k	ent's Usual (done du	ion ring most of work	king	16b. Ki	nd of Busines	ss Indu	stry
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2 shou h and 7 is m traum		19a. Informant's Name/Relati					-		d Number or Rur					,
and and Healt tem 2		Ricardo Santi 20a. Method of Disposition	ago/Fai	ther	20b. F	118618 Place of Dispos			Place, M	ontgome Date		illage		D. 20886
Page 1 nent of nt: If i		1 Burial 2 X Crema 4 Donation 5 Oth		oval from Sta	te C	cemetery, crem	natory or oth	er place)						Virginia
rmit. F spartm sporta sporta iy inju	_	21. Signature of Funeral Pervi).1 0					of Facility De				<u>,</u>	VIIgInia
n pen		Much	Lul	N	لىلى				r Park I			sburg,	MI	20877
Physician/ Medical		23a. Part 1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)	e, or complicati ist only one ca	ions that caus use in each li	ne	h. Do not ente			such as cardiac	or respiratory an	rest,		1 1	Approximate nterval Between Daset and Death
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rtificat ling ph e as th	/Mec	IF FEMALE:											1	
v requires that the death certificate to been signed by the attending physishould be detached for use as the light	Physician/Medio	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1	If yes, outcorr 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknowr	2 Feta at time of	al death 3 🗌	Ectopic pre Other (spec				1	23d. Date of o Month		y day Year
hat the led by 1 detach	y Ph	Part II. Other significant con	ditions contrib	uting to death	but not res	sulting in the u	nderlying car	use giver	n in Part I.	23e. Did to	obacco u	se contribute	to the	cause of death?
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an; Th	Be C	25. Was case referred to med	cal					26. Plac	e of Death (Chec	1 ☐ Yes k only one)	2 🔀 No	1 L Y	es 2	□ No
hysici his ce I direc	卢	examiner? 1 Yes 2 1	Hosp	ital: 1 ☐ Inpa	tient 2 🗆	ER/Outpatien	t 3 🗆 DOA	Other:	4 Nursing Ho	ome 5 🗷 Resid	dence 6	Other (Spe	ecify)	
ending P eath. or: After t he funera	Certificate:		nding estigation	28a. Date of in (Month, D	jury ay, Year)	28b. Time of injury	28c	. Injury a work? 1 🔲 Ye	at es 2□No	28d. Describe h	ow injury	occurred		
ital or Att			termined 2		njury - At ho tc. <i>(Specif</i> y	ome, farm, stre	et, factory, c	ffice		28f. Location (S City or Tow		Number or F	Rural R	oute Number,
To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys, completed filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medic	al Examiner:	On the basis of	examination	n and/or investi	gation, in my	opinion,	date and place, ar death occurred a	t the time, date a	nd place,	and due to the	e cause	e(s) and manner stated
vith Tot		29b. Signature and title of cer	The state of the s	Nell			29c. L	icense n	number			e signed (Mor		
		30. Name and address of pers	son who compl	eted cause of	death (Item	1 23a) (Type, Pi	rint)	V.J.	į.		<u>Janu</u>	ary 3,	∠∪	TT
		Stuart B. Tay					venue,	# :	301, Gai	thersbu	rg,	Maryla	nd	20879
State Registra		31. Date filed (Month, Day, Yea	2011	32 Regist	rar's Signa	ture for	NO S							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month DECEMBER Physician/ A^{M} 6:25 CLAUDETTE EUGENIE COOK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours Min. MARCH Day Ocar 1950 GUYANA 60 577-78-9950 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Examiner must be notified at Director 1 💢 Yes 2 🗌 No FREDERICK FREDERICK MD10g. Citizen of What Country? 10f. Zip Code ъ 10e. Street and Number 23a Funeral USA 21702 114 FEATHERSTONE PLACE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Black, White, etc. 5 þ 1 Never Married 2 Married Yes 2 X No BLACK Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 27 is marked other than "natural", traumatic event, the Medical Exar Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ADMINISTRATIVE ASSISTANT PRIVATE 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည VERONA V. EVANS CHARLES CUMMINGS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FEATHERSTONE PLACE FREDERICK, MARYLAND 21702 JANELLE MURRAY/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WASHINGTON CEME 1/8/11 <u>ADELPHI, MARYLAND</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B.JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 Turn, fighting that a real the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 23a. Part 1. Enter the disea. , shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Metastatiz disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Year Day Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗌 No Yes 2 No 1 🗌 Yes **Division of Vital** 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: 2 1 Tes 2 🗷 No 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: s after death. I Director: After t work? 1 ☐ Yes 2 ☐ No injury 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Directo completed filled in by t 4 Homicide determined the Hospital Medical Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MOD 65183 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick, mD 21701 Haiying 400 W 7th St Liana 31, Date filed (Month, Day, Year) 32. Registra s Signat re State JAN 0 4 2011 Registrar

Please Type or Print in Black Indelibie and Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ hathrun nnessa 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center 5. Social Security Number 8. Date of Birth
Jan. 25, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. Days Year 1932 Hours Onio 1 M 2 L Director 78 273-30-6486 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince George's Glenn Dale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 7603 Lake Glenn Drive 20769 **USA** 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🕅 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates. Specify: 3 Widowed 4 Divorced White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Accounting Supervisor Sun Trust Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Warren D. Host Virginia Comings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angelo T. Dannessa/ Husband 7603 Lake Glenn Drive, Glenn Dale, MD 20769 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State Ba Tirmore Washington Crematory 4 ☐ Donation 5 ☐ Other (Specify) 12/28/2010 Laurel, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licen 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions or any, leading to immediate cause. Enter Underlying Cause (Disease or linjury pue to (or as a consequence or). Exami and -transit death certificate be executed that initiated events resulting in death) Last physician a s the burial-t Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death Day 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has autopsy performed 1 Yes 2 No ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be B 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes <u>ا</u> 🖊 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes Accident Investigation Suicide Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29b. Signature and title of certific eted cause of death (Item 23a) (Type, TNNAPOUS MANYSI FE NSE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 2010 Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

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Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month December 2010 6:00 p Medical a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 6. Sex 1 ♣M 2 ☐ F 9. Birthplace (State or Foreign Country)
New York If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Year) 19<u>28</u> Days Hours Months 200-16-9449 82 Vrs **Director** Jan. or items 23a or 28a-f shov miner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director Maryland Montgomery Rockville 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Fletcher Place 20851 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Forces?
1 ☑ Yes 2 ☐ No World
If Yes, Give
Year or Dates. War II Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 XXWidowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
U • S • ARMY (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Audit Agency permit. Page 1 and 2 should be filed witl Department of Health and Mental Hygier Important: If item 27 is marked other t any injury or other traumatic event, the once. Auditor æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Dunn Anna Shawley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Patrick Dunn (Son) Salford Way, Simpsonville, SC 29681 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date race of Disposition (value of semetery, crematory or other place) ate of Heaven emetery Mausoleum 1 \square Burial 2 \square Cremation 3 \square Removal from State Gate 4 ☐ Donation 5 🖾 Other (Specify) Entombment Silver Spring, Maryland 22. Name and Address of Facility DeVol Funeral Home, 21. Signature of Funeral : e) ice Licensee (M00689)10 E. Deer Park Drive, Gaithersburg, MD 20877 Inlet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hear failure. List only one cause on each line. stood Interval Between Immediate Cause (Final Onset and Death ENDSTAGE Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** 7 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ The law requires 1 Yes 2 No 3 Probably 4 Unknown Vital Records, Completed CIERHORI 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 certificate 2 🗌 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 2 X 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes 2 🗌 No s after death 2 Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours af

To the Funeral Di

completed filled ir Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Gertifying Nurse Practicgues To the best of my knowledge, drieth commed at the time, date and plane, and due to the o 29b. Signature and title of certifie 29c. License number 15+1 ho completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso

State Registrar ELCIOT K
31. Date filed (Month, Day, Year)

JAN 03

201

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DESEMBLE DI 20 YOU 12.30AM Elliott Shirlev Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CLEM BURNIE BINLE BALTIMORE WARHINGTON MEDICAL CAN 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) Funeral Month, Day, Y 1 🗆 M 2 🔯 F Months Hours Country) Arkansas 74 432-62-5650 Director .1936 Usual Residence of Decedent or 28a-f show notified at 10b County 10d. Inside City Limits 10a, State 10c. City. Town or Location death with the Maryland Director Anne Arundel Pasadena MD 1 ☐ Yes 2X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò ral", or items 23a or Examiner must be r USA Funeral 21122 1152 Booth Bay Harbour 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin White 1 Yes 2 No Specify: Completed 3 Divorced Baltimore, Maryland 21215-00 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Anne Arundel County life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Police Department Booking Officer Be 18. Mother's Name (First, Middle, Maiden Sumame)

Lydia Elizabeth Owen 17. Father's Name (First, Middle, Last) 2 Kenzie Kenneth Langley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1152 Booth Bay Harbour Pasadena, MD 21122 BUIDTY Josiah O. Elliott / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 2 2010 ry, crematory or other place, 1 ♥ Burial 2 Cremation 3 Removal from State Crownsville, MD MD Veterans Cemetery 4 Donation 5 Other (Specify) Fur eral Service Livenses Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ METAGRATIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying as the burial-transit Cause (Disease or liniury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ğ Month Day Year Pregnant at time of death the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Completed by pe 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an . Were autopsy findings available prior to completion of cause of has autopsy page 2 perforn death? 2 - No 1 Yes 2 No certificate ☐ Yes or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No 1 Tes 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer (Month, Day, Year) Natural injury 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatu 29d. Date signed (Month, Day, Year)

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Registrar

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32. Registrar's S

ed cause of death (Item 23a) (Type, Print)

and address of person who comp

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State Registrar	State of Ma		epartm <i>Certific</i>				giene Reg. No.	010	42795		
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Funeral Director			Sex 1 □ M 2 🔽 F	70 Yrs. The strict of the stri							thplace (State or Foreign untry) rginia		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fitem Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	o	10a. State 10b. County	I	10c. City, Town	or Location						10d. Inside City Limits		
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to the hospital or Attentioning Prostorian: The law requires that the beauth certificate be within 24 burst after death. To the Euneral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the burneral director.	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	2 🗀 Fetal death	3	pic pregnanc r (s <i>pecify</i>)	ży		23d.	23d. Date of delivery Month Day Year			
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2		30. Name and address of person who	seempleted cause of de	ath (Item 23a) (I	Type Print)	100	13 1	ND 21	401/	CHAL	Es P. Asmo W		
Stat Registra		31, Date filed (Month, Day, Year) DEC 2 9 2	2010 32. Registrar	's Signature	San	Ve /		,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician ROBERTA **EVANS** JULIA PM Dec 2010 2:42 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Talbot Genesis HealthCare -The Pines Easton 8. Date of Birth (Mgnth, Day, Year) 04/06/1926 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 ☐ M 2 🖾 F 215-20-0759 Maryland 84 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Evaniner must be notified at Crisfield Maryland Somerset 1 Tx Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 325 Somers Cove Apartments 21817 U.S.A. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐Yes 2XNo Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2 K No Specify 3 Widowed 4 Noivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cashier Grocery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willard Landon Alvenia Wilson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any Injury or other trau
once. 3519 Indian Grant Road - East New Market, MD 21631 Terri D. Hughes (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunnyridge Memorial Park 12/31/2010 Crisfield, MD 21. Signature Fulleral Service Licensee

Robert H. Brack 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, Robert H. Brackbaw, Jr. 306 W. Main St. - Crisfield, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21817 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cute myocar diel **Physician** ntuales /Medical s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner years newsderosis burial-tran Due to (or as a consequence of) physician the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 pronths? Month Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗆 No 1 ☐ Yes 1 □ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 □ Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

with the Maryland

Baltimore, Maryland 21215-0036

Evans

Julia

To the

State Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

(ROWL 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 610 1)UTCH MANS

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 24, 2010 12:01 AM Anita Elizabeth Ferragame Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sacred Heart Home Hyattsville Prince George's Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** Days Min. 1 □ M 2 🎝 F Months Dec. 14. Pennsylvania Hours Director 180-20-3479 95 Usual Residence of Decedent artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 X Yes 2 No Prince George's Mary land | Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 4801 King Court 20720 Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) LPN Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic e Emedio Amadio Virgilia Saghetti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Lee Shaw/ Daughter 4801 King Court Bowie, MD 20720 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/29/2010 Glen Burnie, Md Atlantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home alle Show 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia 42a disease or condition ENU Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Month Day Pregnant at time of death Year ned by the a g 🗌 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe shoufd be o Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? this certificate Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Other: မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at After 5 Pending injury 1 W Natural work? 24 hours after death Funeral Director: A Investigation 2 No Accident 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (A

Box 68760

Division of Vital

-1900

lazan

Registrar's Signature

Sa

9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Year 12/26/2010 **Physician** 5:30 P M George Vincent Foskey /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Berlin Nursing and Rehabilitation Cen. Berlin Worcester If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Date of Birth (Month, Day, **Funeral** Months Days Hours 1 M 2 □ F 215-26-4971 83 MD 9/5/1927 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County show "natural", or items 23a or 28a-f shovidical Examiner must be notified at MD Pittsville 1 ☐ Yes 2 No Wicomico Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4537 Powellville Rd. 21850 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Specify: white 1 ☐ Yes 21 No Specify: 2 3 □Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Farrier/ Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be nd 2 should be fi Ith and Mental H 27 is marked oth r traumatic ever s 1 and 2 should b Health and Ments tem 27 is marked Will Foskey Ella Bratten 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alice Scott (daughter) 4537 Powellville Rd. Pittsville, MD 21850 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Powellville Cemetery | 12/30/2010 | Powellville, MD 21. Signalure of unera 22. Name and Address of Facility The Burbage Funeral Home rvice Licenses 108 William St. Berlin, MD 21811 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 16 days Bilateral Pneumonia /Medical Due to (or as a consequence of): Examiner 16 days b. Non ST Segment Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-tran Due to (or as a consequence of) physician Physician/Medical the attending I for use as 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, coronary Artery Ds 2No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy perform certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes XXNo 1 🗍 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After ification: (Month, Day Year) 1 🖪 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Physiclan: Attending by the f

death with the Maryland

Baltimore, Maryland 21215-0036

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Hospii 24 hour 25 Funer etely fill	dicai	29a. Certifier (Check only one)	2 Medical Examiner: €		eath occurred at the time, date and place, a r investigation, in my opinion, death occurre		
To the vithin To the compl	Me	29b. Signature an	/ /	٠, ١	29c. License number	29d. Date signed (M	fonth, Day, Year)
		1	can Cis	my DO	Н 0070020	December 2	28, 2010
, ,		30. Name and add	dress of person who complet	ed caus of death (Item 23a) (Typ	oe, Print)		

0 State Registrar

31. Date filed (Month, Day, Year) -28-2010 32. Registrar's Signature 0 3 2011

Diane Ceruzzi, D.O. 9715 Healthway Dr., Berlin, MD 21811 Denve S. park

	1	For State Registrar		Stat	e of Ma	ryland	-	ertificate of l		nd Mer		giene leg. No. 0	10	42799
Physician		I. Decedent's Name	e (First, Middle, t Willi		guson			-	-		Date of Dea	oth 5, Day 01	0 Year	3. Time of Death 3:11 A M
/Medica Examine Funeral	r 4	la. Facility Name (If 90 C1ub 5. Social Security No	House	Drive 6. Sex	7. Age		ast birthday	4b. City, Town, Berlin If Under 1 Year Months Days	If Under 24	4 Hrs. 8.	Date of Birth	W		
Director		157-20-3. Usual Residence of	Decedent	1 🙀 M 2 🗆		81	Yrs.			Ma	ay 2, Pay	1929		10d. Inside City Limits
show d at	.	10a. State	10b. County	ator			Town or l erlin							1 ☐ Yes 2 ☐ No
the M	Director	MD 10e. Street and Nur	Worce	SLEI		ינג	CITII	10f. Zip Code				10g. Citizen o	of What Co	untry?
3a or			b House	drive				218	R11				USA	
	by Funeral	11. Marital Status 1 □ Never Marri 3 □ Widowed	ied 2 Marri	12. Was Arm ed 1 1	Decedent Education Forces? Yes 2 Nesses, Give		5. 13	B. Was Decedent of If Yes, specify Cui	Hispanic Origi pan, Mexican,	in? (Specify Puerto Ric	y Yes or No- can, etc.)	14. R B	lace - Ame lack, White	rican Indian, e, etc. 7hite
n 72 hou "natural edical E)	Completed	(Spec	15. Decedent cify only highes	t grade compl		16a. Decedent's Usual Occupation (Give kind of work done during most of work)				of working		16b. Kind of Business/Industry		
giene.	E O	Elementary/Seco	ndary (0-12)	C21	ege (1-4or 5+	Chief of Police						Washi	ngton	n DC
tal Hyg	Be C	17. Father's Name	(First, Middle, L	.ast)								Maiden Surn	ame)	
Ment Ment Marker	<u>-</u>	Albert			41		10h Ma	iling Address (Stree			Connor		vn State 2	Zin Code)
id 2 sh Ith and 27 is n traun		Lois H.						Club Hous						-rp 0 0 0 0 0)
Pages 1 ar nent of Hea nt: If Item 3 iry or other		20a. Method of Disp 1 ☐ Burial 2 4 ☐ Donation	cosition Cremation	3 □ Removal		CE	ace of Dis emetery, c	position (Name of rematory or other pl cate Crem	ace)	Date 2-31-2	е	20c. Location	n - City or	
permit. Departm Importa any Inju once.	r	21. Signature of Fu	ineral Service I	icensee	nd			22. Name and Add		Dur	_	uneral		
Physician /Medical Examiner s the burial-transit	dical Examiner	shock, or hea Immediate Cause (disease or condition resulting in death) Sequentially list condition in the cause of the cause (Disease or that initiated events resulting in death) in the cause (Disease or that initiated events resulting in death) in the cause (Disease or the cause (Disease or that initiated events resulting in death) in the cause (Disease or the cause (D	(Final on onditions, nmediate orlying injury s	a	ue to (or as a	a conseque	uence of):	ARTER	y Di	15E	ASE	dis	QU.	Interval Between Onset and Death
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w requires that the dispersion been signed by the should be detached	ক্র	Part II. Other signi	ficant condition	ns contributin	g to death bu	not resu	ulting in the	e underlying cause of	iven in Part I.		23e. Did t			o the cause of death? robably 4 death
sician: The law rec certificate has bee irector, page 2 shou	Completed	OF Mee cook rote	grad to madical	7					26 Plane	of Dooth /	24a. Was auto perfo	psy ormed? 2 No		utopsy findings available completion of cause of
/sicla	o Be	25. Was case reference examiner?	No	Hospital	1 ☐ Inpatie	nt 2 🗆	ER/Outpat	tient 3 DOA	thor:	rsing Home		dence 6 🗆	Other (Spe	ecify)
ding Phy h. After this funeral c	⊢⊦	27. Manner of Dea 1 Natural 2 ☐ Accident	th 5 Pendin	g	Date of Injur (Month, Day		28b. Time Injur	y W		28		how injury oc	curred	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could r determ		Place of injubuilding, etc	iry - At ho	ome, farm,	street, factory, offic	е	28		Street and No wn, State)	umber or F	Bural Route Number,
ne Hospit: n 24 hours ne Funera sletely fille	Medical C	29a. Certifier (Check only one)	Certifying Medical	Examiner: Or	To the best on the basis of d manner sta	examina	wledge, de tion and/o	eath occurred at the r investigation, in m	time, date an y opinion, dea	nd place, ar	nd due to the d at the time	cause(s) and , date and pla	d manner a ace, and du	as stated. ue to the cause(s)
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12+1 E	7	30. Name and add	VAR	who complete	orta	FC '	214	FRANK	NU	Ai	E.	BER	711	MM.
Stat Registra	_	31. Date filed (Mor	JAN 0	3 2011	Je negistra	ar s oigha	A.	franke)						1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 27 3010 12:06 AM Roland Fenwick, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Cheverly rince George's Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. July 26, Months Days Hours Country) 579 50 4427 **Director** 70 DC Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1X Yes 2 No MD Prince George's Capitol Heights 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 915 Minna Avenue 20743 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner! Armed Forces?
1 ☐ Yes 2X No Black White etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐xNo Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Custodian DC Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George R. Fenwick Rosa Cunningham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kent Vines/ Son 6205 Hardbargain Circle Indian Head, MD20640 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Harmony Cemetery 1/3/2011 Landover, MD 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Licenses 2294 Old Washington Rd.Waldorf,MD edu 23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CARDIAC ARRHYTHMIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immedia cause. Enter Underlying Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deeth.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death
Unknown Month 5 Other (specify) Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ျှ 1 🗆 Yes 1 M Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: Tutle best of my knowledge, dieth consined at the firm, date and plane, and due to the narrotal and marrier as stated 29b. Signature and title of certifier 29c. License number 30, 2010

7CB3

P.O. Box 68760

Records,

State Registrar

31. Date filed (Month, Day,

JAN04

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 26, Physician/ Marion B. Florin 2010 9:30 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 7407 Cedar Avenue Takoma Park Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs, last birthday) Funeral Days (Month, Day, June 10, 1 M 2 D Months Hours Min. Director 007-09-6928 97 Missouri Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No MD Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7407 Cedar Avenue 20912 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🙀 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Franklin Brantley Bertha Ellen Hicks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roland E. Florin/Husband 7407 Cedar Avenue, Takoma Park, MD 20912 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan. 1,2011 Alexandria, VA Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver Signature of Funeral Service Licenses 504 Part /. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prysician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ttending physician and for use as the burial transit Cause (Disease or iinjury requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last ysician/Medical ords, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🛣No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 M Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 \square Pending

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Cert

Accident Suicide

4 Homicide

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Division of Vital Rec	o the Hospital or Attending Physician: The lar ithin 24 hours after death.	the Funeral Director; After this certificate ha
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Divis	pital or A	eral Direc
	o the Hospital or Attendir ithin 24 hours after death.	the Fune

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Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29c. License number D29353 December 28, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George Graves, MD 5530 Wisconsin Avenue, Chevy Chase, MD 20815

1 Tes

2 🗌 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Investigation 6 Could not be

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Jiii Jiii	1- For State Certific	eate of Death	Reg. No.	72002
Physician Medical Examine	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year December 12, 2010	3. Time of Death 0834 hrs
	Facility Name (if not institution, give street and number) University Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Deat	h
Funeral Director	5. Social Security Number 220–11–8005 6. Sex 1 7. Age (In yrs. last bird 2 X F 25	thday) If Under 1 Year If Under 24Hrs Months Days Hours Min	1 o.	rthplace (State or Foreign puntry) Maryland
und show any ace.	Usual Residence of Decedent 10a. State	or Location timore		10d. Inside City Limits 1 Yes 2 No
t the Maryland as or 28a-f show otified at once.		10f. Zip Code 21225	10g. Citizen of What Cou	ury? USA
and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shorranmatic event, the Medical Examiner must be notified at once. To Be Completed by Furneral Director	Widowed 4 A Divorced or Test, sive Year or Dates:	13. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 X No specify: Decedent's Usual Occupation (Give kind of v	Rican, etc.) White, etc. Specify:	ican Indian, Black, Thite Industry
5-0036 led within 72 hour lygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use reti n/a	n/a	
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than ic event, the Medica	Jerry L. Gammon, Sr.		(First, Middle, Maiden Surname) y L. Kendrick	
MD 21 dd 2 should ulth and Me m 27 is ma aumatic ev		b. Mailing Address (Street and Number or 6 533 Baja Way, Elkrid		
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and h Important: If item 27 is n injury or other traumarte	1 V Puriol 2 Cromation 3 Permayal from State cremat	of Disposition (Name of cemetery, ory or other place) and Nat. Cemetery 12		Maryland
	23a. Part Enter the disease, or complications that caused the death. Do not		Road, Laurel, Mary	and 20707 Approximate Interval
Physician Wedical xaminer	failure. List only/one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of):	,,,,,		Between Onset and Death
Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
ted 1 ansit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			
760, icate be executed by physician and the burial - transit	UNPENDED AMENDED			
P.O. Box 6876 that the death certificate need by the attending phydeached for use as the by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknown 23c. If yes, outcome of pregnancy 1 Live birth 4 Pregnant at time of death 9 Unknown	Fetal death 3 Ectopic pregna Other (Specify)	23d. Date of deliven Month	y Day Year
rds, P.O. E requires that the been signed by the hould be detached	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacco use contribute to	
Reco The law cate has page 2 s			autopsy prior to death? 1 ✓ Yes 2 No 1 ✓ Yes	topsy findings available completion of cause of
Vital F hysician: this certifi al director,	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Ou	26.Place of Death (Check of De	only one) g Home 5 Residence 6 Other	
ion of trending Pheesth. tor: After the funeral ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury Dec 12, 2010 9453	Time of Injury 28c. Injury at Work? 3 hrs 1 Yes 2 ✓ No	28d. Describe how injury occurred Subject shot	
Division o spital or Attending tours after death. Increase Director: After filled in by the fune Gertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa (Specify) Local Street	arm, street, factory, office building, etc.	28f. Location (Street and Number or Ru or Town, State) 1300 Block of N. Franklintown Road	
Division To the Ropital or Attentil within 24 hours after death. To the Funeral Director: A completely filled in by the fi	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred a	t the time, date and place, and due to the	e cause(s)
. 77	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Mor	
AZ.	30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Exami	iner 111 Penn Street, Baltimore	e, MD 21201	
State Registrar		parker		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Ronald Lee Griffie 10:36 PM DRC Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Denton Caroline 27782 Burrsville Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs 1 **X** M 2 □ F Months Hours West Virginia 373071938 219-26-9209 Director Usual Residence of Decedent th an Mental Hygiene. 27 is arred other than "natural", or items 23a or 28a-f show trau atic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director Denton Caroline Maryland 1 Yes 2 1 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 27782 Burrsville Road 21629 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 White 1 ☐ Yes 2xxNo Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Gunsmith Private ould be filed with Mental Hygien arked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Manuel Griffie Nadine Long 1 and 2 should in the Meritan Meritan Meritan Meritan Inc. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 317 Hillsmere Drive, Annapolis, MD 21403 Bonnie Griffie - Daughter permit, Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🙀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 🗋 Donation 5 🗀 Other (Specify) Hillcrest Mem Garden's 12/28/2010 Annapolis, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home in Ti delen Myslin 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Physician NASAL CAVIE chwie Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): ŵ Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be eximined to the control of the cours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the burl Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death Pregnant at time of death 3 in the past 12 months? Yes 2 No 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Medical Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 2010 erson who completed cause of death (Item 23a) (Type, Print

State Registrar

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		1	For State Registrar	State of M	arylan		oartme e <i>rtifica</i> :				giene Reg. No.	010	12804
	Physicia		1. Decedent's Name (First, Middle, Lass David Gieger)							2, Date of Dea Month	Day	Year 2010	3. Time of Death
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and the	- Francisco		5. Social Security Number 6.5	land Med		en K		or 1 Year	If Under 24 Hrs.	8. Date of Birl	th	N/A 9. Birt	hplace (State or Foreign
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	and show dat	ō	10a. State 10b. County		10c. City	y, Town or L	_ocation				-		10d. Inside City Limits
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	with the 23a or 1st be n	eral D	10e. Street and Number 3731 Crossbow Ct	•			10f. Z	ip Code	21042		•	of What Co SA	untry?
	items	1 14 1	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S	S. 13	8. Was Dece	edent of Hi	spanic Origin? (Sp. n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Amer Black, White	
900	rs after or Iral", or Examir	Completed by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2本 If Yes, Give Year or Dates.	No		1 🗆 Yes				- 1	ecify: Wh	
15-0	"2 hour "natu edical	plet	15. Decedent's E (Specify only highest gr			(Giv	edent's Us	ork done d	ation Juring most of work	ing	16b. Kind	of Business	ndustry
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Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) Raymond W. Gi	egerich		•			18. Mother's Nam Lois	e (First, Middle, Shriver		name)	
Mary	2 should Ith and M 27 is ma r traumar		19a. Informant's Name/Relationship (7) Pamela McLeod-Gie		vife		iling Addre		nnd Number or Rur	al Route Numbe			Code) 1042
ore,	permit. Page 1 and Department of Hes Important: If item any injury or othe once.		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	l c	emeterv. cr	position (Na ematory or remat	other plac	e) 12/2	Date		ion - City or	Town, State ryland
altim	mit. Pag partmer portant / injury		4 ☐ Donation 5 ☐ Other (Special Service Lice)		ALG				i	1/2010			y FH, Inc.
ä	an)		KJLK 1-	8		4	112 0	1d C	olumbia I	ike El	licot		, MD 21043
	Pnysician/	85 00	23a. Part / Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final	plications that caused one cause on each line	Э.			de of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	Due to (or as	a consequ	uence of):				/	l e ok		
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Box 68760	death certificate be ne attending physici ed for use as the bu	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			B Ctopic	: pregnanc	ev		230	d. Date of de	livery
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ls, P.O.	the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and the Funeral Director. After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit	ed by Pł	Part II. Other significant conditions of	contributing to death b	out not res	ulting in the	e underlying	g cause giv	ren in Part I.				the cause of death?
Division of Vital Records,	sician: The law req ; certificate has bee lirector, page 2 sho	Completed by								24a. Was auto perfic 1 Yes		prior to death?	topsy findings available completion of cause of
Ea F	cian: T ertifica ector, p	Be	25. Was case referred to medical examiner?	Hospital:					ace of Death (Chec				
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ion	tending leath. tor: Afte the fun	Certificate:	1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be			injury	M		Yes 2 No				
Divis	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,		4 Homicide determined	28e. Place of Inj building, et	ury - At ho c. (Specify	me, farm, s	street, facto	ory, office		28f. Location (umber or Hu	ral Route Number,
	To the Hospital within 24 hours a To the Funeral Completed filled	Medical	(Check 2 Medical Exam	rsician: To the best of niner: On the basis of e rse Practioner: To the	examination	n and/or inv	estigation, i	n my opinio	on, death occurred a	at the time, date	and place, an	d due to the	cause(s) and manner stated.
	To the To the Congression	_	29b. Signature and title of certifies	- MA				9c. License				igned (Monti	
	•		30. Name and address of person who	completed cause of c	death (Item	1 23a) (Type	e, Print)	Jezin	932 Aledi		•		
	-01		University of Many 31. Date filed (Month, Day Year)	land Med	ar's Signa	ture	V 2	25	Green St	reet	Balton	none t	(OSIS CIT
	Sta Registr		JAN 3 2	JII Leven	w,	B. A	barke		_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month GREENE 234 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MANDRIN HOSPICE HOUSE HARWOOD Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 1 🗆 M 2 🗷 F Months Days Hours 27, 1919 NEW JERSEY 91 FEBRUARY Director 149-09-3035 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MARYLAND PRINCE GEORGES UPPER MARLBORO 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 12400 FOYETTE LANE 20772 UNITED STATES 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Specify: BLACK 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Should be filed with and Mental Hygien 7 is marked other th 12TH GRADE PAYROLL SPECIALIST FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, JOHN D. SEENEY ISABEL ROSETTA REED SEENEY permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is mar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 12400 FOYETTE LANE, UPPER MARLBORO, MARYLAND 20772 KYLE CAMILLE ADAMS / DAUGHTER Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) LINCOLN MEMORIAL CEMETERY JANUARY 5, 2011 SUITLAND, MARYLAND and ure of Fundal Service Los na THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, LYDIA C. THORNION JOHNSON MO0583 MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause ilinjury Due to (or as a consequence of) sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Day Yea Pregnant at time of death sate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 유 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at DICE 28d. Describe how injury occurred 1 Natural 5 Pending injury after death. 1 Yes 2 No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of c∯rtifier 30. Name and address of person who completed cause of death (Item 23a) (Type Print) ENTA MY41 EFENSE

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day,

Year)

JAN 0 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 29, 2010 Physician/ December 9:22P Rebecca Gaines Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Ft. Washington Ft. Washington Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 9/13/1950 60 Pennsylvania **Director** 163-42-2426 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he maritical annote. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director Maryland Prince George Temple Hills 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3338 Huntley Square Dr. Apt. B2 20748 USA 12. Was Decedent Ever in U.S. Armed Forces?...
1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: Black 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward Thomas Cherry Chapman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Brown/Sister 400 Oak Hill Dr. Apt. 106 Pittsburgh, PA 15213 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Kalas Crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 1/5/2011 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sign ture of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, MD 20745 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner RANSVER Sequentially list conditions, Examine ir any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 No 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) 욘 1 ☐ Inpatient 2XX ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manyler of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D42955

Registrar

30. Name and address of person who completed cause of peath (Item 23a) (Type, Print)

Edgar V. Porter MD 11701 Livingston Rd. Ft. Washington, MD 31. Date filed (Month, Day, Year) JAN 0 4 2011

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20744

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2320 **Physician** ARLES 2 26 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) July 19, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Min. Days 12 M 2□ F Yrs. 214-20-7945 86 1924 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show d other than "natural", or items 23a or 28a-f sho event, the Medical Evantian, rust by notified at 1 ☐ Yes 2 X No Director Anne Arundel Severna Park 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 and 2 21146 831 Ritchie Hwy. USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 XYes 2 ☐ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: White 1 ☐ Yes 2 🛛 No Specify. 2 unk 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Lawyer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles C. Hartman, Sr. Carolyn Crane ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joyce Hartman/Wife 7940 West Riverside Drive Pasadena, MD 21122 Date 28, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dec 2010 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Rarranco & Sons, P.A. 21. Signature of Funeral Service Licensee Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy. 23a. Part 1. Enter the disease, or complications that caused the disath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUMONIA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-larinsit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Mapner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Nate signed (Month, Day, Year) 29c. License number 301 Name and address

31. Date filed (Month, Day, Year) State 282010 Registrar

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sally Hermann 2010 11:02P M December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Vermont 6. Sex 7. Age (In vrs. last hirthday) 8. Date of Birth Funeral (Month, Day, Yea April 02, Months Days 1 🗆 M 2 🗓 F Director 70 019-32-7667 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Sussex DE Lewes 1 ☐ Yes 2 🛭 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14686 Pleasant Pond Way 19958 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Yes 2 X No þ 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. School Teacher Elementary Education is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ပ Ellen Sullivan Guy Margie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Hermann / Husband 14686 Pleasant Pond Way Lewes, DE 19958 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) December 2010 Baltimore, MD Metro Crematory, INC 21. Signature of Funeral Service Licensee Name and Address of Facility, P.A. Severna Park Funeral Home Ritchie Hwy, Severna Park, MD 21146 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examir and -transit Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à

To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 Records, P.O. Division of Vital

Baltimore, Maryland 21215-0036

3				1 L Yes 2 L No 3 L Probably 4 Unknown		
Potologo				24a. Was an autopsy prior to completion of cause of death? 1 ☐ Yes 2☐ No 1 ☐ Yes 2 ☐ No		
١			26. Place of Death (Chec	k only one)		
L C		Hospital:	ne 5 Residence 6 Other (Specify)			
ertificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred		
i Corti	5	28e. Place of Injury - At home, farm, street, fac building, etc. (Specify)	ctory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
Modio	29a. Certifier (Check 2 Medical Examironly one) 3 Certifying Nurs	ician: To the best of my knowledge, death occure ner: On the basis of examination and/or investigation e Practioner: To the best of my knowledge, death o	, in my opinion, death occurred a	t the time, date and place, and due to the cause(s) and manner stated.		
	29b. Signature and title of certifier	\wedge	29c. License number	29d. Date signed (Month, Day, Year)		
	1 1	MAD	1000-7/75	- Den 28 2010		

State

Registrar

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death December 29, 2010 Physician/ 10:45P. M Hickerson James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Laurel Morningside House of Laurel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 109-14-5096 1 ₹ M 2 □ F 87 Hours Min. June 7 1923 New York Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examinar must he motified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Maryland 1 Yes 2 X No Charles Waldorf 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20603 United States 6106 Pooka Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married Completed by White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Graphic Artist AT and T Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, မ Barbara Vormwald James Hickerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig J. Hickerson -nephew 6106 Pooka Court Waldorf, Maryland 20603 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State Metropolitan Crematory 12/30/2010 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Type I Service License Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland 20705 an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): as the burial-trensit The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ģ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Yes 1 ☐ Yes ∠ ☐ 9 ☐ Unknown the 9 I Ilnknown page 2 should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has death? 1 Yes 2 No 25. Was case referred to medical 24 hours after death.

Funeral Director: After this certific eted filled in by the funeral director, To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 🔀 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical To the Funer Completed fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Dree Krimar MD D15512 Sushama December 30, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sushama N. Sreekumar, M.D. 5711 Sarvis Avenue, #200 Riverdale, Maryland 20737 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 03 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 29, 11:30 a M Theresa Troiano Higgins 2010 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Rockville Montgomery Montgomery Hospice-Casey House If Under 1 Year | If Under 24 Hrs. 8 Date of Birth 9 Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday Funeral (Month, Day, Aug. 20, Min Country)
D. C. Days Hours 1 M 2 X F 90 Yrs Director 578-18-3510 Usual Residence of Decedent 10d. Inside City Limits an "natural", or items 23a or 28a-f shov M-dical Examiner must be notified at 10b County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director MD Silver Spring 1 Yes 2 X No Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20904 3126 Gracefield Road, #218 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. þ 1 Never Married 2x Married Saltimore, Maryland 21215-0036 White 1 Yes 2 No Specify. Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business Industry during most of working than, College (1-4 or 5+) Elementary/Seconday (0-12) the 3 Administrative Assistant Federal Government and Mental Hygie is marked other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file.
Department of Health and Mental H.
Important: If item 27 is marked any injury or cert 17. Father's Name (First, Middle, Last) 2 Anna DeLuca Antonio Troiano 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3126 Gracefield Road, #218, Silver Spring, MD 20904 Paul J. Higgins, Sr./Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Jan. 3, Gate of Heaven Cemetery Silver Spring, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licens 500 University Blvd. W., Silver 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Multiple Myelama disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause Enter Underlyin Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last the burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 ası IF FEMALE nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Live Sirth 2 Live Birth 2 Live Bregnant at time of death Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Veal for 5 Other (specify) the detached 9 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Upper GI Bleeding, Chronic Kidney Disease-Stage IV . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed certificate has death? 1 ☐ Yes 2 ☐ No Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical funeral director. Hospice Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 မ After this 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certificate: 5 Pending Natural s after death.

I Director: Aft Accident Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide City or Town, State) 24 hours Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D37142 15-54-5010

Registrar

DHMH 17 Rev 7/2009

State

1355 Piccard Drive, Rockville, MD 20850

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. Coleman, MD

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ December 29, 2010 Octave Najib Habesch 5:00 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Holy Cross Hospital Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Palestine 1 🙀 M 2 🗆 F Months Feb. 26, 1923 Hours Director 577-96-1653 87 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 28a-f 1 Yes 2 X No MD Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code ö 10g. Citizen of What Country? 23a Funeral 406 Waterford Road USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. by 1 Never Married 2 🙀 Married 2 😾 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural" 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) should be filed with and Mental Hygien 7 is marked other th Physician Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Najib Habesch Babila Manuel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 406 Waterford Road, Silver Spring, MD 20901 Maria Octave Habesch/Wife 1 and 2 s of Health item 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite Page 1 1 Burial 2XX Cremation 3 Removal from State Jan 2011 Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Hemathorax disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** End-Stage Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) certificate be executed Congestive Heart Failure Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): use as the burialattending physician Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year Pregnant at time of death been signed by the saluding should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has page 2 1 Yes 2 No **Division of Vital** Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 2 X No ၉ 1 Yes 1 🕱 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 only one) the within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar Ira Rabin, MD 31. Date filed (Month, Day, 1500 Forest Glen Road, Silver Spring, MD 20910

32/Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D61887

December 29, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician ecenber 26 2010 OberTa ian /Medical 4a. Facility Name (# not institution, give street and number) 4b. City, Town, or Loca ion of Death 4c. County of Death Examiner everan Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 1 □ M 2 🗗 F **Funeral** Year) Min 215-20-2202 8 Marylano Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryia Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examinat must be nutified. 1 □Yes 2 No Director aM 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number reys Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) State College (1-4or 5+) HUSP:ta Stant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HOMPSON ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Prin) Road Cambridge, MULLIA 1/00 James 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State terans Cemetery HUVLOCK, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Henry Funeral Home, P. A. 510 washington St. Cambri MD.21613 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Arterioscheralic difere Cordiovelculer Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Considerve Loon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (r as a consequence of) Examiner be executed burial-transit Due to (or as a consequence of): Box 68760, physician Physician/Medical requires that the death certificate the as attending p for use as IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 I Unknown signed by the 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy nerforme certificate 1 Yes 2 Line 1 ☐ Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\text{Nursing Home} \) 1 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 1 No 1 Thipatient 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MO 12.26.2010 D47924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAOBRIDGE MD 21613 503 BYRN NONGAN 11thoway 31. Date filed (Month, Day, Year)
(JAN 0 3 201 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

		For State Registrar	Pleas	• •			d / Dep		of H	k. Ensure / lealth and l Death	-		2011	e.	42813	3
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Funeral Director		5. Social Security N 415-14-1		Sex 1 x M 2		e (In yrs. la	ast birthday, Yrs.	If Under 1 Months	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	th ay, Year)	923	Countr	ace (State or Foreign y) ennessee	7
faryland Ba-f show tified at	ector	Usual Residence of 10a. State MD	10b. County P.G				y, Town or L lver	ocation Spring						10	d. Inside City Limits	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Mayland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Insportant: I frem Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 ☐ Never Mam 3 ☐ Widowed	ied 2 🖈 Married	Armı 1 🗌 If Ye	Decedent Bed Forces? Yes 2 1 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9		3. 13		/ Cuba	ispanic Origin? (Sp n, Mexican, Puerto Specify:		-	14. Race - Ar Black, WI Specify: Wh	nite, et	c.	
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To the hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death, as after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-trans	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									23d. Date of Month	d. Date of delivery Month Day Year		_		
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4		30. Name and address Rachell		completed			23a) (Type,			silver	Sprina	M	125/2	90	4	_
Stat Registra		31. Date filed (Mont)			32/Registra	ar's Signat	yre d	west.			1)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 7:30 een ecember 21 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Year) 1 □ M 2 💢 F Months Days Hours Min 67 Yrs 212-44-0678 Feb. 08,1943 **Director** Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show or 28a-f show notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Anne Arundel 1 ☐ Yes 2 X No Arnold 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? must be 408 Century Vista Drive 21012 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 【XNo Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ral", or iter Examiner 1 Never Married 2 X Married Baltimore. Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. \$ White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nursing Home 12 Receptionist traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mark S. Barrett 2 Delores Chealsman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Kohlhafer/ Husband 408 Century Vista Drive Arnold, MD 21012 permit. Pages 1 and Department of Healt Important: If Item 2: any Injury or other 1 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Loudon Park Cemetery 2010 21. Signature of Funeral Service Licensee Name and Address of Facility P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a contequence of) **Examiner** Sequentially list conditions, if a yelloding to in model cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Die to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Tectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No After this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 \square Residence မ 6 Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 Yes 2 No hin 24 hours after death the Funeral Director: A 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated the within 7

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31. Date filed (Month, Day, Year) State DEC 282010 Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32. Registrar's Signature

16256

29d. Date signed (Month, Day, Year)

2010

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600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene a HCHD, a legister Amend #18, 1-11-2011, per FHDIC ertificate of Death

State of Maryland / Department of Health and Mental Hygiene a legister from Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jayne Ann Koskinas Month Year 9-53 AM Dec Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death altimore Afnes Hospita none 7. Age (In yrs. last birthday) 58 vrs If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Days 1 □ M 2 🛣 F Month Hours Min Month, Day, 6/195 Director <u>553-92-8332</u> Indiana Usual Residence of Decedent 28a-f show 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County items 23a or 28a-f sho ner must be notified at 10d. Inside City Limits Director MD Highland Howard 1 ☐ Yes 2X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7141 Deer Valley Road 20777 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 XMarried þ Baltimore, Maryland 21215-0036 1 Tes 2 No Specify If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working th and Mental Hygiene.
27 is marked other than traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Consulting Dietician</u> Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Eleanore Serban Eleanor Serban George Koskinas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 130 Highland, MD 20777 Theodore N. Giovanis - Husband permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Ardent Cremation 1/3/11 4 Donation 5 Other (Specify) Hanover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc 4112 Old Columbia Pike M01044 Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ reast carcinen disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ai Ure Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to Air as a grinswinger file use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☒ No Month Year Pregnant at time of death Day 1 Yes 2/2 9 Unknown detached Unknown P.O. signed by Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page 2 To the Hospital or Attending Physician: The I within 24 hours at er deatt.

To the Funeral Director: After this certificate h performed 2 No Yes 2 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 🔊 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 🔀 Natural 1 ☐ Yes 2 ☐ No Accident Investigation the 1 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The defice of Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 64583 Dec 31, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pitch and Caten Arenu, Baltimore MD Hisupama D-Mitikisi, St. Agres Hospital, 900 Caten Arenu, Baltimore MD

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Registrar

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32. Redistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010^{Year} Physician/ Mary Alice Kelly December 29 11:15 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Brighton Gardens of Tuckerman Ln. Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex Birthpia. Country MD Funeral 1 🗆 M 2 🏝 I Months Days Hours Month Day, 1928 218-24-1052 Aug. Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits death with the Maryland Director MD Rockville Montgomery 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5550 Tuckerman Lane, 20852 USA Rm. 522 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. 0 ģ 1 Never Married 2 Married ☐ Yes 2x No Yes, Give Maryland 21215-0036 hours after 1 ☐ Yes 2 x No Specify Specify. White 3 → Widowed 4 □ Divorced marked other than "natural", Completed Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 72 Elementary/Seconday (0-12) College (1-4 or 5+) Agent Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file ပ္ Charles B. Dustin Edna E. Miles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i 13217 Maplecrest Drive, Potomac, MD 20854 Brenda D. Foote/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Jana 3, permit. Page 1 and Department of H 1 KBurial 2 Cremation 3 Removal from State Union Cemetery-Burtonsville Burtonsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Francisco Grand Corrections of Funeral Home In 500 University Flvd. W., Silver Spr. 23a. Part Intertwedisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, francis d'dd coriffis Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death Immediate Cause (Final Pnysiciani a. Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Atherosclerotic Heart Disease yrs Secura fielly list scriding if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the burigh Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown Yes 2 No the 9 Unknown signed by t d be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Parkinson's Disease 1 ☐ Yes 2X2·No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performed death? After this certificate I 1 ☐ Yes 2 ☐ No Yes 21 No 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital Other: 2 🙀 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA ျ 4 K Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1x Natural 5 Pending in 24 hours after deam.
The Funeral Director: Aff Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and titl 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and addre

31. Date filed (Month, Day, Year,

MD

JAN 03

10810 Darmestown Road, #202, Gaithersburg, MD 20878

s of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

019609

Dec. 30, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decement's Name (First, Middle, Last) Physician/ AM ES Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number **Examiner** Anne Arundel Severna Park 43 West McKinsey Road If Under 1 Year If Under 24 Hrs. 5. Social Security Numbe 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** (Month, Day, Year) an. 18,1928 1 🗶 M 2 🗆 F Months Hours Maryland 212-24-2075 82 Jan. Director Usual Residence of Decedent shov 10b. County 10c. City, Town or Location Severna Park aţ 10a. State 10d. Inside City Limits with the Maryland Director permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f slany injury or other traumatic event, the Medical Examiner must be notified a Anne Arundel MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21146 USA 43 West McKinsey Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? 1X Yes 2 □ No 1946þ 1 Never Married 2 X Married Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Specify: Completed 3 Widowed 4 Divorced 1973 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Telecommunication 5+ Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Sophia Moreland John R. Llewellyn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43 West McKinsey Road Severna Park, MD 21146 Edith R. Llewellyn / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State Delaware Veterans 4 Donation 5 Other (Specify) 2010 Bear, Delaware Memorial Cemetery . Signature of Fund Service Licenses Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Ent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause or each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 4 Pregnant 9 Unknown Month Day Year Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown r signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Q 2 No 3 Probably 4 Unknown Completed page 2 should peen Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform death? 1 ☐ Yes 2 ☐ No Yes in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 1 Yes within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral directors. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔼 Natural 5 Pending 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town. State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

To the 81/8

State

31. Date filed (Mont Registrar

30. Name and addre

(Check only one)

Registrar's Signature

on who completed cause of death (Item 23a) (Type

ORIGINAL

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				State of Maryla	and / Depa	rtment of H	lealth and M	ental Hygien	e	
			for State Registrar		•	tificate of l		Reg. N	2010	42819
	Physici	an	1. Decedent's Name (First, Middle, Last)	1				Date of Death Month Date	ay Year	3. Time of Death
	/Medic		Lam She	Iton L	nch			Dec. 2		12100 P.M.
	Examin	ner	4a. Facility Name (If not institution, give to 108 Graces 4	arreet and number)		~	Location of Death	40	Sucen	Anne
AREA .	Funeral		5. Social Security Number 6. Sex	7. Age (In)	yrs. last birthday)	If Under 1 Year		8. Date of Birth (Month, Day, Year		lace (State or Foreign
	Director		81122123411	M 2□F	59 Yrs.	Months Days	Hours Min.	Aug. 2,1		yland
puo	A		Usual Residence of Decedent 10a. State 10b. County	10c.	. City, Town or Loc	ation			11	0d. Inside City Limits
Maryland	-f sho	tor	MD Queen A	Inne's	Guns	on Ville	٥			1 ØYes 2 □ No
7 4	or 28e)irec	10e. Street and Number		Olas	10f. Zip Code		10g. C	itizen of What Coun	try?
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0	items	Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No	I .		lispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, e	
5-0036	eal", or	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	□Ye <i>s</i> 2☑No	Specify:		Specify: Blo	CK
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בו פולים	tal Hygiene.	Be Co	17. Father's Name (First, Middle, Last)		Chart	er wal		(First, Middle, Maide		10980
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6 , 5	Department of Health and Mer Important: If item 27 Is marke any injury or other traumatic once.		20a. Method of Disposition	nch	108G	YACES		rasonvi	1/e, M.[ocation-City or To). 2/638 wn. State
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Saltimor	Department of moortant: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		bryans 22		ss of Facility	30/10/GY	250ny. 11	e, 1110.
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VISION	er dea rector by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, stre	et, factory, office	2	28f. Location (Street a City or Town, Sta	and Number or Rura	al Route Number,
2 5	ırs aft ral Di					. –				<u> </u>
Hosp	24 hor Fune etely fi	Medical		sician: To the best of my ner: On the basis of exan and manner stated.						
To the	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certifier			29c. Licens	se number	29d. E	Date signed (Month,	Day, Year)
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	7		30. Name and address of person who co		(Item 23a) (Type, I	Print) – /1	0000	- 1/	1 71/	7
	Sta	ete.	31. Date filed (Morth, Day Year)	2. Registrar's S	ignature	greatle !	WAI) Co-	mente "	1 0101	/
	Registr		31. Date filed (Morfit, Day, Year)	Centra .	p. pa					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Frank Sylvester Lepore M December 2010 0400 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6432 Lochridge Road Columbia Howard Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Days (Month, Day, Yea, 02/28/192 1 🛛 M 2 🗆 F Months Hours Min. Director 170-12-5785 89 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** be notified 1 🗌 Yes 2 🛂 No MD Howard Columbia 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? ems 23a 6432 Lochridge Road 21044 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 🖾 Yes 2 🗆 No 1942-Black, White, etc ŏ 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Divorced 4 Divorced 1945 White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Microfilm Technician Kodak Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) item 27 is marked other traumatic ev ပ David D. Lepore Angelina Mirabella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane M. Reitz - Daughter 6404 Lochridge Road Columbia, MD t: If item 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State of 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/05/2011 Gate of Heaven Silver Spring, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of): disease or condition resulting in death) EFES Medical Examiner YEARS O RONARDY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine bunial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? To the Funeral Director; After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for Day 4 ☐ Pregnant at time of death g ☐ Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) ne Hospital or Attending Pin 24 hours after death. 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury 2 Accident 1 Tyes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my onion, death baccurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cert

State Registrar 30. Name and address of person

31. Date filed (Month, Day, Year)

11055 Little

PATURENT PINEUR

Colembry

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who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

LEVINE, NO

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep. State Amend Items 23a, 26 per dr., g912, Registrar Cel	artment of Health and Northicate of Death	lental Hygie	ene 3. No. 2 () ()	12821		
			1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death		
	Physicia Medic		James I. Muckelvene		December	² 20, 2010	7:00pM		
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death				
			6. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Upper Marlboro If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince G	eorge 's		
	Funeral Director		227–76–7850 1 M 2 🗆 F 58 Yrs.	Months Days Hours Min.	(Month, Day, Ye	1952 Virg	inia		
	_ M		Usual Residence of Decedent						
	yland -f show ed at	cto	10a. State 10b. County 10c. City, Town or Lo	ocation		1	0d. Inside City Limits 1X Yes 2 No		
	e Mar r 28a notifi	Director	MD Prince George's Bowie 10e. Street and Number	10f, Zip Code	10g. Citizen of What Country?				
	/ith th	rall	14103 Gamma Ct.	20715	100	USA	try ?		
	ems :	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - Americ	an Indian,		
ထ္ထ	filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 🖾 Married 📗 1 🖾 Yes 2 ☐ No	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🛣 No Specify:	Rican, etc.)	Black, White, e	etc.		
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yla	should be file h and Mental f 7 is marked o traumatic eve	욘	James M. Muckelvene	Effie	Battle				
Nar	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at			ng Address (Street and Number or Rura			Code)		
e,	and 2 Healt tem 2		Pearline Muckelvene/Spouse 1410 C			20715 Oc. Location - City or To	wn State		
nor	Page 1 ment of l ant: If it		1 Kurial 2 Cremation 3 Removal from State cemetery, crem	matory or other place) ans Cemetery 12/2		cheltenham,			
Baltimore, Maryland 21215-0036	permit. Page 1 Department of Important: If i any injury or c			2. Name and Address of Facility		neral Home			
m	a in the second		/ fort	6512 NW Crain Hwy.	, Bowie	e, MD 2071	5		
	Physician/ Medical Examiner	ner	23a. Part. Enter the desease complications that caused the death. Do not ent shock, or heart nue. Learning one cause on each line. Sarcamoto Immediate Cause (inal disease or condition resulting in death) Sequentially list conditions, if any, leading to find distance of the conditions of the conditions of the conditions.	d Carcinoma of Production	A N C.	£	Approximate Interval Between Onset and Death Months		
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Records,	The law resate has be	Completed			24a. Was an autopsy performe	prior to co	osy findings available mpletion of cause of 2 No		
ta	ician: Sertific ector,	Be	25. Was case referred to medical examiner? [Hospital:	26. Place of Death (Check		418.1			
o t <	ing Phys fter this ineral dir	ate: To	1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 27. Manner of Death 1 Sala Date of injury (Month, Day, Year) 28b. Time of injury	nt 3 DOA 4 Nursing Ho 28c. Injury at work?		ce 6 🛭 Other (Specify injury occurred dau ho			
Division of Vital	I or Attending Physician: after death. Director: After this certific in by the funeral director.	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str	M 1 ☐ Yes 2 ☐ No reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural	Route Number,		
á	spital or nours aft neral Di	ledical C	29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death	occured at the time, date and place, an			d.		
	the Ho thin 24 h the Fu	Med	(Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	death occurred at the time, date and place	e, and due to the ca	use(s) and manner as sta	ated.		
			29b. Signature and title of certifier Cypthia M. Juliams, 50	29c. License number H00 5803 9		1. Date signed (Month, I Secenber &			
	AN SINE		Name and address of person who completed cause of death (Item 23a) (Type, F		Washim	iton . KC.	20010		
	Stat Registra	e	31. Date filed (Month, Day, Year) UEC 2 8 2010 32. Registrar's Signature	barles	V V COI WI C	7.100			
			The state of the s						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Theresa Mayer 1:00 Рм 2010 December Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Severna Park 213 Sycamore Road Social Security Number If Under 1 Year I If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🛛 F Months Hours (Month, Day 81 214-26-2862 **Director** 09.1929 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Severna Park 10d. Inside City Limits the Medical Examiner must be notified at Director MD Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 213 Sycamore Road 21146 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian. Armed Force Black, White, etc. ò þ 1 Never Married 2 X Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 White id Mental Hygiene. marked other than "natural", If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) State of Elementary/Seconday (0-12) College (1-4 or 5+) Home/Maryland Hospital Homemaker/ Nursing Aid any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked c Alice Theresa Hyson Joseph Edward Skipper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 213 Sycamore Road Severna Park, MD 21146 Joseph A. Mayer, Sr./ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Decembe 1

▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MD Veterans Cemetery Crownsville, MD 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Par 1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final em Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated as each of the control of the con Examine Due to (or as a consequence of) and -transit that initiated events resulting in death) Last Due to (or as a consequence of): nding physician a Physician/Medical death certificate be Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Month Pregnant at time of death 5 Other (specify) Day Year g 🗌 Unknown s been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 Tes Yes To the Hospital or Attending Physician: within 24 hours ther decth.

To the Funeral Pirector After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes Other: 2 NO ၉ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work' 5 Pending 2 🗌 No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State

Registrar

Name and address of person who completed cause of

31. Date filed (Month, Day, Year)

death (Item 23a) (Type, Prigt)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month McCleskey, Jr. Heartwell December 2010 11:12 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 680 Americana Drive, Apt. 21 Annapolis Anne Arundel 7. Age (In yrs. last birthday) 87 yrs 9. Birthplace (State or Foreign Country) Mississippi 8. Date of Birth
(Month, Day, Year)
July 24,1923 **Funeral** Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Days 1 X M 2 □ F Months Hours Min. 432-28-6986 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 680 Americana Drive, Apt. 21 21403 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 and 2 should be filed within 72 hours after d if Health and Mental Hygiene. item 27 is marked other than "natural", or i 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hours postartment of health and Mental Hygelne. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Traffic Manager/Kraft Foods Kraft Foods Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Heartwell S. McCleskey, Sr. Rita Proby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lee McCleskey / Son 1542 Star Pine Drive Annapolis, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, INC Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licensee CREMATION DIFFECT 495 Ritchie Hwy Severna Park, MD 21146 23a. Part 1. Enter the line st., or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ reposit CANCIC Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or ilinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? ate has been signed by the atte page 2 should be detached for Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Ø Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No ☐ Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifies 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ignatu 29d. Date signed (Month, Day, Year) 12/23/1 1)65272

State

Box 68760

P.O.

Records,

of Vital

Division

Registrar DHMH 17 Rev 7/2009 Jacks

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

a)c

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MILANESE SANDRA 10,00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3535 Old Trail Edgewater Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Rhode Island Funeral 7. Age (In vrs. last birthday) 8. Date of Birth Months 1 M 2 F 12/30/1941 026-32-9493 68 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f shov dical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland| Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3535 Old Trail 21037 USA 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 X No If Yes, Give Year or Dates. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify White 3 X Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Owner-Operator Floral vears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oliver Wilbur Ethel Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mario S. Zampiello/ Son 14061 Eagle Chase Circle, Chantilly, VA 20151 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Natl. Cem. 2/2/2011 Arlington, VA 21. Signature of Juneral Selvice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NG disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) requires that the death certificate be executed anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be (Division of Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 S Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: A 2 🗌 No Accident Investigation Could not be 1 🗌 Yes completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type Print)

MICHAEL J. L. FENTA WO YY (DETENCE)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)
UEC 2 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 4:00 a M Wilda Lake Montgomery December 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Glen Burnie 1028 Fairway Avenue 9. Birthplace (State or Foreign if Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, yrs. last birthday) **Funeral** West Virginia Months 83 1 □ M 2 💢 F 233-40-7938 **Director** 11,1927 April Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County filed within 72 hours after death with the Maryland **Funeral Director** Glen Burnie MD Anne Arundel 1 ☐ Yes 2 🔀 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21061 USA 1028 Fairway Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc Armed Force Completed by 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural", 3 XWidowed 4 ☐ Divorced permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Isabelle Lyons Forest Castro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1028 Fairway Avenue Glen Burnie, MD 21061 Leonard Castro / Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial December Elkridge, MD 2010 Park . Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 <u>Severna Park,</u> Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ Hou) ancec Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or) attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ned by the atter detached for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by necleurion 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? 2 🗌 No certificate 1 🗌 Yes Yes Division of Vital Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical director, æ examiner? Hospital: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မှ this s after death.

I Director: After this of in by the funeral di 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) thin 24 hours af the Funeral Di mpleted filled ir Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Pragtioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the I only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State Registrar Kitche

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HILLIARD MAURICE MCCARTER Month Physician/ DEC 27 4:20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA 5. Social Security Number 7. Age (In yrs. last birthday) 86 yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 9, 1924 9. Birthplace (State or Foreign **Funeral** Texas 1 🛛 M 2 🗆 F Days Hours Min. 465-16-5546 Director Usual Residence of Decedent ıral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Tes 2 X No Prince George's Ft. Washington Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 20744 Funeral 8003 Carey Branch Place 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married ¥ Yes 2 ☐ No Yes, Give 10 1941 altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural" 3 Widowed 4 Divorced Specify: White Year or Dates. 1971 other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)
Military I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Navy 12 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Collins McCarter Mattie Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife McCarter 8003 Carey Branch Place Ft. Washington, MD 20744 Dorothy Μ. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State 1 🔲 Burial 2 💭 Cremation 3 🗌 Removal from 1/4/2011 4 🔲 Donation Kalas Crematory 5 Other (Specify) Edgewater, Maryland 21. Signatur 22. Name and Address of Facility George P. Kalas Funeral Home P.A. f Funeral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 20745 a Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final Onset and Death Physician/ PROSTATE CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 2 No 2 😾 N Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 😾 No ျ 1 🖾 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending Accident
Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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32, Registrar's Signature

USN

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NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend 29c per HD, DOR, Certificate of Dooth

Certificate of Dooth 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month noore ames PE Medical .ember 10:10 A-M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPice 0 Hune's entre Queen Alle If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Ye Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗷 M 2 🗆 F Days Hours Months Min. Director Usual Residence of Decedent shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f Anne's 1 Yes 2 No Ueen rrason ville 10e. Street and Numb 10g. Citizen of What Country? items 23a Funeral 96 Chester Wye Center 21638 death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married 0 Black, White, etc. þ 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced Specify: Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than should be filed within and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) t. Page 1 and 2 should be filed with them of Health and Mental Hygien rant: If item 27 is marked other 1 jury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 10 Mes Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Centreville Marchelle ans 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) sterfield Cemetery 129 21. Signature of Funeral Service Licensee 22. Name and Address of acility Henry Funeral Home, P.A. 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final chrysician/ Onset and Death ab disease or condition e Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Dus to (or as a consequence or After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 🗌 Yes 2 🗫 o 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 PNo မ Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Wher (Specify) Hospice 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident 1 Yes 2 No Investigation Could not be within 24 hours after death

To the Funeral Director:
completed filled in by the 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title ertifier 2 D32036 12/22/20/0 30. Name and address of terson who completed cause of death (Item 23a) (Type, Print) 2108 1) Worth mor Choka V

DHMH 17 Rev 7/2009

State

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 27, 2010 **Physician** December 5:17 P M **JEAN** MISTER **BARBARA** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Somerset McCready Memorial Hospital Crisfield If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 02/09/1936 Days Hours Months 1 M 2 X Maryland 74 220-32-0172 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Jem 27 is marked other than "natural", or items 23a or 28a-f show other tranmatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10h. County 1 ☐ Yes 2 ☑ No Crisfield Maryland Somerset Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21817 3079 Boone Road U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Owner Antique Shop 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Eddie Cook Eugenia Tyler 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra James Mister (Husband) 3079 Boone Road - Crisfield, MD 21817 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sunnyridge Memorial Park 12/31/2010 Crisfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Lie 22. Name and Address of Facility Bradshaw & Sons Funeral Home gnature Funeral Service Licensee Robert H. Bradshaw 306 W. Main St. - Crisfield, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due tutor as a consequence of): Examiner Sque tially list no filled if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760. physician Physician/Medical the attending p SE IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1☐ Yes 2☐ No Day 4□Pregnant at time of death 5 Other (specify) P.O. P ed by the a detached f 9 Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed? es 2 No this certificate 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 1 TYes 2 ER/Outpatient 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1niury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

State Registrar 31. Date filed (Mont

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar #11, Certificate of Death D.H. WCHD Reg. No. Amended item 01/03/11, per F. H. 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ 12 7 27 / 2010 Pay 11:00 P M Iola Wanda Michelson Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 16 Duck Cove Circle Berlin Worcester Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min 6/22/1924 MA (Country) Director 86 008-14-3455 Usual Residence of Decedent show 10a. State 10b. County filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City. Town or Location 10d, Inside City Limits Director MD 1 ☐ Yes 🛣 ☐ No Worcester Berlin 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 16 Duck Cove Circle 21811 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important. If item 27 is marked other i any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Hopkinson Sadie Lutz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles A. Michelson (husband) 16 Duck Cove Circle, Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Fernation 3 Removal from State First State Crematory 12/30/2010 Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD. 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 100 0 WWdisease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been rector, page 2 shoul 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 2 No 1 Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Hospital 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c, Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) n 24 hou... the Funeral Direc. 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year)

State

Registrar

DHMH 17 Rev 7/2009

Steven

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOGAOI

Suite 301

Berlin Me 2181

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 24, 2010 8:00А. м Physician/ Joseph Madden Francis Medical 4a. Facility Name (if not institution, give street and number)
Futurecare Old Court 4b. City, Town, or Location of Death
Randallstown 4c. County of Death Examiner Baltimore 9. Birthplace (State or Foreign Pennsy Ivania Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Months Days 1 🔀 M 2 🗆 F March12 1929 195-22-4705 81 **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director Prince George's Maryland Beltsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 20705 10g. Citizen of What Country?
United States 11906 Beltsville Drive, #4 Funeral 12. Was Decedent Ever in U.S. Arneed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates 1947–1952 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify White Specify: "natural", Completed 3 Widowed 4 X Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Industrial Production Tech Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mary Ellen McDonnell Francis Patrick Madden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 249 S. Ellwood Avenue Baltimore, Maryland 21224-2211 Jeanne Madden -daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

Maryland Veterans Cemetery 1/13/2011 1 X Burial 2 Cremation 3 Removal from State Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Service Licensee Bonalad V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown certificate has been signed by the rector, page 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No 1 Yes 1 🗌 Yes iours after death.

leral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending work?
1 Yes 2 No 1 Natural injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined ...n 24 hours ah. fo the Funeral Dir-completed fill-City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Cectiffing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 057722 DECEMBER 28 2010 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 1838 GREENE TREE RUAD #300 PILLESVILLE MD 21208 LEUNARD RICHARDSON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 03 Registrar

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month - Belansky Frances Mary Mcgaw December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12509 Shoemaker Way North Potomac Montgomery Social Security Number 8. Date of Birth Aug. 15, 1928 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2 TX F Months Days Min. 109-22-6655 82 Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director MD Montgomery North Potomac 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 12509 Shoemaker Way 20878 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ò þ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 an "natural", Medical Exar 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 ☐ Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Educator Beauty School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) 2 William Aniken Rose McNally 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Jude Mariah Marney/Daughter 12509 Shoemaker Way, North Potomac, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State December 2010 Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, VA 22. Name and Address of Facility
DeVol Funeral HOme, 10 East Deer Park Drive,
Gaithersburg, MD 20877 21. Signature of Funeral Service Licenses TRACUA Juves M01117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final) Physician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Diabetes Mellitus Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Hypertension Completed Parkinson's Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 XNo of Vital Hospital or Attending Physician: 25. Was case referred to medical director. Be 26. Place of Death (Check only one) 1 Yes Other: 2 X No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) eral Director. After th filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Division 2 Accident
3 Suicide
4 Homicide death. 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after determined 24 hours Medical 29a. Certifier 1 K Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner. Of the basis of examination areas of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Iv within 2-29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

Birthplace (State or Foreign Country)

 Tiles

White

10d. Inside City Limits

Approximate Interval Between

Onset and Death

Day

1 Yes

Year

1 Yes 2 No

11:45 A.M

2010

State Registrar

30. Name and address of person with completed cause of death (Item 23a) (Type, Print)
Monica Jean Howard, M.D., 20528 Boland Farm Road, Suite 104, Germantown, MD 20876 31. Date filed (Month, Day, Year)

00053213

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 30, 2010 Donabelle Fodor McGriff 2:45 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sanctuary at Holy Cross Burtonsville Montgomery Social Security Numbe If Under Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min July 23. 1926 Country) Michigan **Director** 376-22-8094 84 Usual Residence of Decedent 28a-f show 10a. State ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🏞 No MD Montgomery Burtonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3415 Greencastle Road 20866 TISA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify White Completed 3x Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Owner Television Repair Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H Robert Griffith Henrietta Donald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 is Pamela Lynn Mizrahi/Grandchild 7171 Winter Rose Path, Columbia, MD 21045 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec. Date permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State 1 Burial 2 x Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2010 Alexandria, VA . Signature of Funeral Service Licenses Name and Address of Facility Tancis J. Collins Funeral Home Inc. M01503 500 University Blvd. W., Silver Spring, MD 20901 23a. Pirt 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Pneumonia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Yes 2 KNo 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Old Stroke, Dysphagia Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 1 ☐ Yes 2 ☐ No Yes 2 🔀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 **X**No ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DCA At Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury X Natural 5 Pending after death. 2 Accident
3 Suicide
4 Homicide 1 Tes 2 ☐ No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

68760 Box P.O. Records, Hospital or Attending Physician: of Vital Division filled in by сотрыете

To the I within 2 7 State (Check

only one) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

well

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009 our

32 Registrar's Signature

mi

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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SmITH AVE

Medical Examiner: On the basis of examination and/or investigation, in the object of the basis of examination and/or investigation, in the object of the basis of examination and/or investigation, in the object of the basis of examination and/or investigation, in the object of the basis of examination and/or investigation, in the object of the basis of examination and/or investigation, in the object of the basis of examination and/or investigation, in the object of the basis of examination and/or investigation, in the object of the basis of examination and/or investigation, in the object of the basis of examination and/or investigation, in the object of the basis of examination and/or investigation, in the object of the basis of examination and/or investigation, in the object of the basis of examination and/or investigation, in the object of the basis of examination and/or investigation, in the object of the basis of examination and/or investigation, in the object of the basis of examination and/or investigation, in the object of the basis of examination and/or investigation and in the object of the basis of examination and/or investigation and in the object of the basis of examination and/or investigation, in the object of the basis of examination and or investigation and investigation a

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	1 - For State Registrar						te of Dea	ith and N	· · · · · · · · · · · · · · · · · · ·	Reg. No.	2 U I U	42833		
cian/ dical	1. Decedent's Na Marian	ime (First, Middl Jean Mil							2. Date of D Month Decembe		2010 Year	3. Time of Death 9:02 p		
niner			n, give street and nur ice-Casey Ho	·		4b. City	, Town, or Loca Rockvil			4c.	County of Deat Montgon			
al or	5. Social Security 213–38–1	.307	6. Sex 1 □ M 2 🛣 F	7. Age (In yrs. 70	last birthday) Yrs.	If Unde Months		Jnder 24 Hrs. burs Min.	8. Date of Bi (Month, D Apr. 15	irth ay, Year) 1940	9. Bir Co Wa.s	thplace (State or Foreigr untry) hington, DC		
ector	10a. State MD	10b. County	tgomery	10c. Ci	ty, Town or Loc	cation Olney	,	_				10d. Inside City Limits 1 ☐ Yes 2 🏋 N		
Funeral Director	10e. Street and N	lumber uehler Cou	ırt			10f. Zi	p Code 20832				zen of What Co	ountry?		
once. To Be Completed by Funeral Director		arried 2 ☐ Mai d 4 X Divorced	rried Armed Fo	2 □ x No ve	If	Yes, spe	dent of Hispanicify Cuban, Me	exican, Puerto	ecify Yes or No Rican, etc.)		14. Race - Ame Black, White Specify: Whi	e, etc.		
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To Be		17. Father's Name (First, Middle, Last) Roy Moorefield							e (First, Middle 1. Hall	National Institutes of Health the, Maiden Surname) Ther. City or Town, State, Zip Code) but City, MD 21043 20c. Location - City or Town, State Silver Spring, MD The Inc.				
	19a. Informant's Name/Relationship (Type, Print) Jeffrey A. Mills/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 4927 IIchester Point Ct., Ellicott City, MD 2								Town, State, Zij , M D 21 0	2 Code) 43				
-	20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 🗀 Donation 5 🗀 Other (Specify)					natory or (other place)	lace) : Jan. 5,				-		
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring MD 20901										1			
ledical Examiner	Immediate Caus disease or cond resulting in deat Sequentially list if my mean of the cause. Enter Un Cause (Disease that initiated everesulting in deat	e (Final tition h) conditions, derlying or linjury ints	a. Due to b. Due to	n-Small (or as a consequence or as a conseque	uence of):	Canc	er with	Metastas	sis			Onset and Death		
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þ	Part it. Other significant conditions contributing to death but not resulting in the dildenying cause given in Part i.													
Completed											prior to death?	topsy findings available completion of cause of		
To Be	25. Was case reference examiner?	_	Hospital:	Inpatient 2	ER/Outpatien	t 3 🗆 D	Other:	f Death (Checi		idence 6	Hospic M Other (Spec			
Certificate:	27. Manner of De 1 X Natural 2 Accident 3 Sulcide	5 Pendi	igation	of injury hth, Day, Year) e of Injury - At he	28b. Time of injury	М	28c. Injury at work? 1 ☐ Yes 2 ☐ No							
	4 ☐ Homicid			ing, etc. (Specif	(y)			and slee -	City or To	wn, State)				
Medical	(Check only one) 29b. Signature ar	2 Medical 3 Certifying	Examiner: On the ba g Nurse Practioner:	sis of examination	n and/or investi	igation, in leath occu	my opinion, de	ath occurred a e, date and place	t the time, date	and place, he cause(s)	and due to the	cause(s) and manner state stated.		
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		71	who completed cau											

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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			For State Registrar		State of M	aryland		partment of l ertificate of l			giene Reg. No.	201	0 42831
	Dharisis		Decedent's Name	(First, Middle, La	st)					2. Date of De	ath	Veer	3. Time of Death
,	Physicia Medio				Donald					DECEMB			
	Examin	er	4a. Facility Name (if		estreet and number) ty Hospita	1			r Location of Death	1		County of Death	
1	Funeral		5. Social Security Nu	ımber 6. S	ex 7. Ag	e (In yrs. la	st birthday,	Lanhar If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird	th	9. Birt	hplace (State or Foreign untry)
	Director		579-70-52 Usual Residence of	243	□ M 2 🔀 F	59_	Yrs.	WOITINS Days	Tiodis Willi.	Month, Da 5/19/I	951	Wash	ington, DC
	show dat	호	10a. State	10b. County		10c. City	, Town or L	ocation		_			10d. Inside City Limits
	Mary 28a-f	Director	MD Prince Georges Bowie									1 K Yes 2 No	
	within 72 hours after death with the Maryland glene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at .		10e. Street and Num					10f. Zip Code	20			en of What Co	untry?
	tems	Funeral	6704 Alex 11. Marital Status	is Drive	12. Was Decedent B	Ever in U.S	. 13	. Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	US 1	4. Race - Amer	rican Indian,
36	after d	ğ	1 Never Marri	No		If Yes, specify Cub. 1 Yes 2 No.		o Rican, etc.)	s	Black, White	e, etc.		
00	ours a	Completed	3 Widowed		16a. Dec	edent's Usual Occur				Whi			
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and	lld be filed Mental Hy iarked oth atic event	To E	17. Father's Name (First, Middle, Last) Raymond McDonald					18. Mother's Name (First, Midd Virginia Dit					
Baltimore, Maryland 21215-0036	shou and is m	i	19a. Informant's Na				19b. Mai	ling Address (Street				own, State, Zip	Code)
δ.	1 and 2 s of Health item 27 other tra	- 1			ski - Sist	_		B Street	Chesap	eake Bea			
nore	age 1 and of H			☐ Cremation 3 ☐	Removal from State	Се	metery, cre	oosition (Name of ematory or other pla	- ' i	Date		ation - City or	
altin	permit. Page 1 Department of Important: If i any injury or once.		4 ☐ Donation 21. Signature of Fun	5 Other (Special Service Licens		IRt.		oln Cemet 22. Name and Addre					
<u>~</u>	Depar Impo any ir	1		Mengane		tu	- 1	3401 Blad	ensburg R	load Br	entwo		20722
П			shock, or hear	t failure. List only o	plications that caused one cause on each line	the death e.	. Do not er	ter the mode of dyir	ng, such as cardiac	or respiratory arr	rest,		Approximate Interval Between Onset and Death
	Ph_sician/ Medical		Immediate Cause (f disease or condition resulting in death)		a	a conseque	ence off:	epsis				-	Offset and Death
10mmers	Examiner	L	Sequentially list cor	ditions	b			potic	mega	@10,	1		
	git q	nine	described to the manufact cause. Enter Underlying Cause (Disease or linjury										
	executed ian and irial-transit	Examine	that initiated events resulting in death) L		C. Due to (or as	a conseque	ence of):						
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Box 68760	ertificat ding ph	/Mec	IF FEMALE:		23c. If yes, outcome	of pregnan	101						
Xo	ath ce attend I for us	Physician/Medical	in the past 12 n	nonths?	1 ☐ Live Birth 4 ☐ Pregnant a	1 Live Birth 2 Fetal death 3 Ectopic pregna 4 Pregnant at time of death 5 Other (specify)			псу			23d. Date of delivery Month Day Year	
О.	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the but the butter of the funeral director.	Phys	9 🗌 Unknown		9 Unknown								
Q,	res tha signed I be de		Part II. Other significance	oant conditions c	ontributing to death b	PA		underlying cause gi	ven in Part I.	23e. Did to			the cause of death?
ords	requii been should	lete	Ro	201		lur	e		-	24a. Was			opsy findings available
3ec	he law Ite has vage 2	Completed by		ricci		(0.					osy rmed? 2 No	death?	completion of cause of
tal	clan: T	Be	25. Was case referre examiner?		Hospital:				ace of Death (Chec		2 - 110		
ζ	Physi rthis c ral dir	<u>د</u>	1 Yes 2 2 27. Manner of Death	No	1 1 Impation 1 28a. Date of inju		R/Outpation 28b. Time of	of 28c. Injur	4 ☐ Nursing H	ome 5 Resid			fy)
ou c	ath. rr. Afte re fune	icate	1 Natural 2 Accident	5 ☐ Pending Investigation	(Month, Day	r, Year)	injury	worl		200. Besonde ii	ow injury c	700di10d	
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 s	Certificate:	2 Cuisida & Could not be				ne, farm, si	reet, factory, office		28f. Location (S City or Tow		reet and Number or Rural Route Number, , State)	
۵	spital		29a. Certifier 1	Certifying Phy	sician: To the best of	my knowle	dge, death	occured at the time	, date and place, a	nd due to the cau	use(s) and	manner as sta	ted.
	in 24 h	Medical	(Check 2	Medical Exam	iner: On the basis of ease Practioner: To the	xamination	and/or inve	stigation, in my opini	on, death occurred a	at the time, date a	nd place, a	and due to the c	ause(s) and manner stated.
	Neith Pot		29b. Signature and t	itle of certifier	1 10	A 15		29c. Licens	1 - 1 .		29d. Date	signed (Month,	, Day, Year)
	^		30 Name and addre	ss of person who	completed cause of de	eath (Item :	23a) (Type.		>60611		10	x 101	12010
2	3		Samue	i Asfa	N MD	8118	6700	D'WCK	ROAD,	LANHA	m,	MARY	LAND 20907
	Stat Registra	_	31. Date filed (Month	2011 A	32. Registra	ar's Signatu	K						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dectember 21. 2010 Physician/ 11:47Р. м Minehan Charles Wayne Medical 4b. City, Town, or Location of Death Silver Spring Facility Name (if not institution, give street and number) 4c. County of Death Montgomery Examiner 13733 Town Line Road . Social Security Number 390–52–1752 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🏻 M 2 🗆 F 60 JAH" PO 1950 Wi§consin Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director ems 23a or 28a-f sh r must be notified a Silver Spring Maryland Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 United States Funeral 13733 Town Line Road "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 X Married à Maryland 21215-0036 If Yes, Give 1968-1972 Year or Dates, 1968-1972 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Completed er than "natur, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha Electrical Engineer private emit. Page 1 and 2 should be filed wi repartment of Health and Mental Hygie nportant: If item 27 is marked other ny injury or other traumatic event: th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Joane Lemke ည Robert Minehan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13733 Town Line Road Silver Spring, Maryland 20906 19a. Informant's Name/Relationship (Type, Print) Susan H. Minehan -wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 20a Method of Disposition 20c. Location - City or Town, State 1/18/2011 permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State Alexandria, Virginia (unk) 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensy Boharad V. Bofgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Adenocarcinoma of the lung Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events at initiated events. Due to (or as a consequence of): and I-transit Exam or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ history of Pancreatic Cancer 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has t autopsy performed? Yes 2 No 1 Yes 2 No after death.

Director: After this certificate 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital Other: 2 💢 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours after To the Funeral Direc determined City or Town, State the Hospital 29a. Certifier 1 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number D61645

State

2

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Mary Ellen Ritchie, M.D.

ompleted cause of Ceath (Item 23a) (Type, Print) e. M.D. 2901 Olney Sandy Spring Road Olney, Maryland 20832

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEYMOUR アをご OR ESKY 11:55 P.M Medical Examiner 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Sanctuary at Holy Cross Burtonsville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 Q M 2 □ F (Month, Day, 5, 1924 Pennsylvania Director 167-12-3633 86 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director MD Prince George's Adelphi 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Completed by Funeral 3.2 should be filed where...salth and Mental Hygiene.
m 27 is marked other than "natural", or items 23: 8105 New Riggs Road 20783 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 □ Divorced Year or Dates. WII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Photographer U.S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fit Department of Health and Mental Important: If Item Z7 is marked any linjury or other traumatic evance. မ Samuel Oresky Rose Edelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan R. Oresky- Son 15620 Aitcheson Ln. Laurel, MD 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Mt. Lebanon Cemetery Jan. 3, 2011 Adelphi S vict Licens 22. Name and Address of Facility 4400 Powder Mill Rpad Borgwardt Funeral Home Beltsville, MD 20705 T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death ANCREATI Physician/ Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): transit. the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day signed by the a d be detached for 1 Yes 2 L 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à THRIVE 10 1 Yes 2 No 3 Probably 4 Unknown Completed USPHACO L 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 After this certificate 2 No 1 Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2. No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury Natural Di 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier P 29d. Date signed (Month, Day, Year) 12 28595 asheen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 SMITH AVE BAYD MD 21209 AKH AIVI, MI ASNEEM 31. Date filed (Month, Day, Year)

JAN 0 3 2011 32. Registrar's Signature State Registrar

Box 68760

P.O.

Division of Vital Records,

State

Registrar

30. Name and addres

ulie

Dang

JAN 03

31. Date filed (Month, Day, Year)

DO

Medical Center

Drive, Rodentle, Manyland

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

9901

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Diana Sue Olmstead Dec 30 2ั0ไ10 1435 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Ye March 20 Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours Min. 1 🗆 M 2 🕱 F Director Yrs. 217-44-8875 64 194dWashington, Usual Residence of Decedent or 28a-f shov mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. artment of Health and Mental Hygiene. portant: If item 27 is marked other than "natural", or items 23a or 28a-f sho if order traumatic event, the Medical Examiner must be notified at in July or orther traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 8700 Jones Mill Road 20815 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Caucasian 3 - Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Police Dispatch City of Laurel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Paul Moores Margaret Farmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6892 Kerrywood Cir., Centreville, VA 20121 Kristin Perdue / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Jan 6, 2011 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cem. Ber and Ber an 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fairfax Memorial Funeral Home M00956 9902 Braddock Road Fairfax, VA 22032 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 the attending phase in the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death been signed by the should be detached 1 ☐ Yes ∠ ¥ 9 ☐ Unknown 9 | Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed Lewy Body Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 performed? certificate 2 🗌 No Yes 2 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical opposition by the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 XNo ပ 1 XInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year)

State Registrar

Division of Vital

8600 Old Georgetown Rd., Bethesda, MD 20814

ddress of person who completed cause of death (Item 23a) (Type, Print)

Rohatgi, MD.,

JAN 03

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Mark Patrick 0'Flynn 2010 6:50p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1507 Sandy Glenn Place Montgomery Sandy Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 271-46-4498 **Director** 60 Ohio May Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Maryland Montgomery Sandy Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1507 Sandy Glenn Place 20860 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. by 1 Never Married 2 X Married 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working alth and Mental Hygiene. 27 is marked other than ", ir traumatic event, the Med life. DO NOT use retired) College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Accountant Utilities Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Mark Thomas O'Flynn Mary Joann Busenlechner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Marie O'Flynn - Spouse 1507 Sandy Glenn Place, Sandy Spring, MD 20860 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 12/30/2010 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring, MD20904 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Physician/ Amyotrophic Lateral Sclerosis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any land line in cause. Enter Underlying Cause (Disease or linjury Examiner Due to for as a conse mence of use as the burial-transit or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No jo Month Dav Year Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? Yes 2 X No 2 🗌 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🛛 No မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending 2 Accius 3 Suicide within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie D0055931 December 27, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tikka Lisa Ng, M.D. 4000 Olney-Laytonsville Road. Olney. Maryland 20832 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. pedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RE TTO Month 083V M 12 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 19105 Wallace Road Prince George's Lanham Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign M 2 - F Days Hours Min. 091-40-5984 Director 73 Nov. Usual Residence of Decedent "natural", or items 23a or 28a-f show e tical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygione. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Mealcal Examiner must be notified at any injury or other traumatic event, the Mealcal Examiner must be notified as 10b. County 10c. City, Town or Location Director 10d. Inside City Limits N.Y. Queens Laurelton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 137-49 231St. 11413 USA 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. Maryland 21215-0036 Yes 2 🔀 No 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Civil Engineer</u> <u>Transportation</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marc Pretto Caciellia Closeil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reginald Pretto/son 65 Cambridge Road Montclair, NJ 07042 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Pinelawn Memorial 12-30-10 Farmindale New York 22. Name and Address of Facility Beall Funeral Home Signature of Fur eral Service Licensee 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or shock, or heart failure. List omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between one cause on each line Immediate Cause (Final Fnysician Paset and Death disease or condition resulting in death) UNG Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 9 Unknown g Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sate has page 2 s performed? Yes 2 2 N within 24 hours after death.

To the Funeral Director: After this certificate 1 🗌 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 Tyes 2/ No Other: မ rt umë 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certificate: 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practionel To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifi 222010 who completed cause of death (Item 23a) (Type Print) NNAPOLIS w 441 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 2 8 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician/ A M OHN 2010 0825 Medical 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner Hosinac HOWARD COUNITY GENERAL HOWARD UMBIA 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X Months Hours Min. Country) MASS Sept. Day 21ar, 1935 029-26-4906 **Director** Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10b County 10a State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Melbourne FLBrevard 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2251 Hampton Greens Blvd. 32935 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married þ Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working r than " . DO NOT use retired) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) filed within tal Hygiene. d other than Disabled Disabled Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Beatrice Moisen ပ Charles Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5267 Rivendell Lane APt.#2, Columbia, MD 21044 Ann M. Rabhadia - Niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, Washington Crem. 12/19/10 Laurel, Maryland 22. Name and Address of Facility Fleck Funeral Home, Inc. 21. Signature of Funeral Service License 7601 Sandy Spring Road, Laurel, Maryland 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ a ARTERIOSCLEROTIC CARDIOVASLULAN disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner Due to for as a consequence of, cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be HYPOTHYROIDISM 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 No 2 NO Yes completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one. Hospital 2 1 No Other: မ 1 Tes 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: ✓ Natural work 5 Pending after death. 1 🔲 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of pertifier D50377

State

Registrar

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2. Registrar's Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PERLINE

2 8 2010

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COLUMBIA MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Frank Pilli. Sr. December 2010 12:01 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 1 X M 2 - F Yrs. Director 220-22-8083 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 X Yes 2 No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 225 Garden Gate Lane 21403 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 and 2 should be filed within 72 hours after d if Health and Mental Hygiene. item 27 is marked other than "natural", or i þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 ☑ Widowed 4 ☐ Divorced White Year or Dates. 1946-48 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Residential Elementary/Seconday (0-12) College (1-4 or 5+) Contractor Construction 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dominic Pilli Rose Gemma Grassio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John F. Pilli, Jr./ Son 197 Hanover Street, Annapolis, Maryland 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 1/3/2011 Crownsville, Maryland 21. Signature por man al Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease of linjury that initiated events the bunial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 Live as Land in the past 12 months? Month 5 Other (specify) signed by the a Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director; for 25. Was case referred to medical 26. Place of Death (Check only one) B Hospital 2 02 No Other: မှ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title 29c. License number D41816 2010

Registrar DHMH 17 Rev 7/2009

Division of Vital

135 Old Selmons Ishu

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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			State of Ma	ryland / Department of Health and	Mental Hygier	P010 12813
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	Funeral			(In yrs. last birthday) If Under 1 Year If Under 24 H	rs 8 Date of Birth	9 Rirtholace (State or Foreign
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24			Usual Residence of Decedent	3 /	001,01,1	120 10 av 910018
	/lanc		10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits
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Maryland	s 1 and 2 should b f Health and Ment frem 27 is marked other traumatice		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or I	Rural Route Number, City	y of Town, State, Zip Code)
	5 = 7 = E		Eartha Harris	1108 West Road	Salisburg	MD 21801
Baltimore,	S 1 au of Hea		20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20	cation - City or Town, State
Ë	Page ment o ant: tf ury or		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	All Hill A III	13/11 11	wal a K MD
臺	artm ortar injui		21. Signature of Funeral Service Licensee	Old Field Cemetery 1	- Cn	urch Creek, ND.
Ba	permit. Departitimport any inj		Douglo a Thomas	22. Name and Address of Facility HENRY Funerall Sio Washingto	HOME, P.A.	1/ 1/10 0///12
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			23a. Part 1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line	ne death. Do not enter the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between Onset and Death
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	/Medical		resulting in death) Due to (or as a	consequence of):		1
	Examiner		S-supplied het ook tillings	Cardiomyopathy		24-
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Вох	atter for u	lar	in the past 12 months?	Fetal death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
Ö	the d	Physician/Medi	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at til 9 ☐ Unknown 9 ☐ Unknown	The of death 5 Other (specify)		
P.O.	The law requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use as the	P.	Part II. Other significant conditions contributing to death but		20. 0:4:1	
ŝ	res tha signed to be det	þ	Tate it. Other Significant Conditions Continuously to death but	not resulting in the underlying cause given in Part I.		use contribute to the cause of death?
5	w require been si should t	Completed			1 ☐ Yes	2 No 3 Probably 4 Unknown
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æ	sician: The law certificate has t irector, page 2 s	E			autopsy performed?	
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Division of Vital Records,	Physician: The this certiticate har director, page	ToB	examiner?	Out.	eath (Check only one)	
of	Phys rthis ral di			ZEE ET VOOR DATE 4 NOT SING	Home 5 Residence	
on	ding P. Afte tune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day)	(ear) 28b. Time of linjury 28c. Injury at Work? M 1 □ Yes 2 □ No	200. 2000/120 1100/110	jury occurred
S	deat deat stor: / the	ca	3 Suicide 6 Could not be		COA Lagration (Charles	
.≥	or A ofter Direction by	E	4 Homicide determined building, etc.	r - At home, farm, street, factory, office (Specify)	City or Town, Sta	and Number or Rural Route Number, ite)
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	Hosi 4 ho Fun ely t	ica	(Check only 2 Medical Examiner: On the basis of e	my knowledge, death occurred at the time, date and pla xamination and/or investigation, in my opinion, death occ	ce, and due to the cause;	(s) and manner as stated.
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	Medical	and manner state	Q.		
	To To	2	29b. Signature and title of certifier	29c. License number	29d. C	Date signed (Month, Day, Year)
)			Mo mo	024986		12/30/10
	10		30. Name and address of person who completed cause of dea	29c. License number 024986 th (Item 23a) (Type, Print) wers ide 0 ~ B101 Sal1560 s Signature		
	0		Robert L. Reilly mo 560 R	werside On Rioi Calich.	na ml.	71801
8	Sta	e ^a	31. Date filed (Month, Day, Year) 32. Registrar	s Signature	10101	
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10-09972 Michael Pilipie Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	State of Maryland /	Department of He	alth and Me	ental Hygiene

		1- For State Registrar		Cert	ificate of	Death			i	Reg. No.		
Physici		1. Decedent's Name (First, Midd							. Date of De	ath	~r	3. Time of Death
Medical Exam	iner	Michael Jerome Pilipie 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death									1901 hrs	
		4a. Facility Name (if not institution 49 Anchorway Road	n, give street and nu	ımber)		Bb. City, Town, o Berlin	r Location	of Death		4c. County Worces		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Yea			8. Date of B	irth (MM/DD/YYY)		
Director		144-50-5731 Usual Residence of Decedent	1 M 2 F	56	Yrs.	Months Day	ys Hours	s Min.	10/7	7/1954	Foreig Co	untry) NJ
*ux		10a. State 10b. County		10c. City, T	own or Location	on						10d. Inside City Limits
* .	_	MD Worce	ester	Ber	1in							1 Yes 2 YNo
arylar 8a-f s at on	cto	10e. Street and Number				10f. Zip Code				10g. Citizen of W	hat Cour	
ith the Maryland 23a or 28a-f sho notified at once,	Director	49 Anchor W	√ay			2181	1			US		
th with tems 2.	Funeral	11. Marital Status 1 Never Married 2		cedent Ever in U.S. orces?		Decedent of Hi es, specify Cuba	spanic Orig				- Ameri e, etc.	can Indian, Black,
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once			1 Yes	2 No	1	Yes 2 X No	specify:			Specify:	W]	nite
ours a atura	d by	15. Decedent's Education (Spec	or Dates:	iles.				16b. Kind of Bu	usiness/I	ndustry		
36 in 72 h han "n lical E	Completed	Elementary/Secondary (0-12)	College (1	I-4 or 5+)		Manager		use retired	1)	Nome T	m n .c.	arrom on t
Joseph Mith	mo	17. Father's Name (First, Middle,	-	<u></u>		Tallagel		's Name (F	irst Middle	Maiden Surname	-	ovement
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Harry Pilipi	.e´				F1o	renc	e Eli	se Mir	COW	_
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours Department of Health and Mental Hygene. Important: If item 27 is marked other than "natur injury or other traumatic event, the Medical Exami	To	19a. Informant's Name/Relations Jena Hreha/D								mber, City or Tow NJ 080		Zip Code)
re, rand f. Healt f. Healt f. f. tem		20a. Method of Disposition 1 Burial 2 X X Cremation	2 Pamoval fr		ace of Disposit	ion (Name of ce	metery,	Ι	Date	20c. Location -		
Pages Pages nent o		4 Donation 5 Other Sp		OIII Otato	-	e Crem	.	12/	30/20	10 Mil		
Baltimore, permit. Pages I as Department of Hes Important: If ite		21. Signature of uneral Service	Licensee			ame and Address		υu.	rbage	Funera	al I	Home
Physician	8 8	108 William St., Berlin, MD 21811 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approxim									3 1 1 Approximate Interval	
/Medical	8 10	failure. List only one cause	on each line.					al dido of the	ospiratory ar	rest, shook, of fiel	art	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		ve Atheroscler consequence of):	olic Cardic	ovascular Dis	sease					,
	_	Sequentially list conditions,	b.	consequence of):								
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	с									
ited J ansit	Exa	events resulting in death) Last	Due to (or as a	consequence of):								
760, ficate be executed g physician and the burial - transit	/Medical	UNPENDED	AMENDED									
ficate be g physici	N N	IF FEMALE: 23b. Was decedent pregnant in th		outcome of pregnar						23d. Date of	delivery	
Box 68 e death certifi the attending ed for use as	Physician	past 12 months?	I Live b	irth ant at time of death	,	al death 3 er (S <i>pecify)</i>	Ectopic	pregnanc	У	Month	D	ay Year
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of Vital Records, ng Physician: The law require this certificate has been signered director, page 2 should be	Completed								24a. Was	osy p		opsy findings available ompletion of cause of
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of Vi	의	1 ✓ Yes 2 No 27. Manner of Death	28a. Date o	<u> </u>	R/Outpatient 8b. Time of Inj		ry at Work			Residence 6 w		Scene
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Division tal or Attendi s after death. al Director: A	ifica		tigation 28e. Place	e of Injury - At home	e, farm, street,	factory, office b	uilding, etc	28			er or Run	al Route Number, City
Spital cours at neral I	S	4 Homicide determ	mined (Specify)					-	or Town, \$	otate)		l.
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical		nysician: To the best niner:On the basis o and manner st	of examination and/								
E 2 E 8	₹	29b. Signature and title of certifier		ateu.		29c. License	e number			29d. Date signe	ed (Mon	th, Day, Year)
		(mude	Hall	2an		O.C.I	M.E.			December	28, 20	10
		30. Name and address of person	•	·	•		145	04004		•	•	
3 <i>E</i>	/	Carol Allan, MD Ass 31. Date filed (Month, Day, Year)	sistant Medical E	Examiner 11 gistrar's Signature	- Penn St	reet, Baltimo	ore, MD	21201				
St Regist		JAN 0 3	2011 6	gistrar's Signature	bar	N. I						

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:24 P^M 2010 Jeanette Pines Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
Washington, DC 1 □ M 2 🕮 F Months Days Hours Min. 3/16/1921 Year) Director 579-12-0264 89 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Bethesda 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20814 7710 Woodmont Avenue, #701 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. White 1 Never Married 2 Married þ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exangines. If Yes, Give Year or Dates Specify. 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Mary Hein Louis Rosenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7710 Woodmont Ave #701 Bethesda, MD 20814 Paula Krainson - Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place, 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 12/22/2010 Falls Church, VA ☐ Donation 5 ☐ Other (Specify) King David Memorial 21. Signature of Funeral Services Licensee 22. Name and Address of Facility Me1589 National Funeral Home 7482 Lee Highway Falls Church, VA 22042 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cardiorespiratory Arrest Medical Due to (or as a consequence of): **Examiner** Se sis Sequentially list conditions, Examine If any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed Pneumonia signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Year Pregnant at time of death Unknown 9 🗓 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 X No has e 2 1 Yes 2 No ivision of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🖁 No Hospital Other: 1 🗌 Yes ျ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred injury 5 Pending XNatural 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D70241 12/21/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shanthi Nadar, MD 2153 Pennsylvania Ave Washington, Dc 20037 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN03 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Amend#23a. Prt.1. PerPhys. PC1-4-11cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 24 Physician/ Sarah L. Proctor December 201010:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) MD **Funeral** 167-14-2138 91 Months Days Hours Min 0971971919 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits MD Montgomery Gaithersburg 1 XYes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 43 Rye Ct. 20878 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) None None 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ၉ Fannie Elizabeth Thompson Charles Honest rmit. Page 1 and 2 should be partment of Health and Men portant; If item 27 is marke y injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43 Rye Court, Gaithersburg MD 20878 William T. Pugh Jr. Son 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of h Important; If ite any injury or ot Date 20c. Location - City or Town. State 1 Durial 2 A Cremation 3 Removal from State Riverdale Park Cre 12/29/2010 Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility DL McLaughlin Funeral Home 2019 MLK Jr Ave SE, Washington DC 20020 21. Signature o Funeral Service Licenses 23a. Part 1. Enter the disease or complications that caused the de th. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hypertension Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner ue to (or as a consequence of) Sensis Sequentially list conditions, if they leading to infraediate cause. (Discouse or links) Examiner DIM to for as a nonsection Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Dementia attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregpant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of death? has autopsy certificate 1 🗌 Yes 2 🗌 No Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes Other: မ 2 🗹 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation
6
Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 24 ho

To the Fune

completed fi (Check Curtifying Nurse Practioner: To the best of my knowled, 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER Day 25 2010 **Physician** 2:19 AM PAYNE ARTHUR /Medical 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S FT. WASHINGTON HOSPITAL FORT WASHINGTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, FEB. 2 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 1 M 2 □ F **Funeral** Months Days Hours Min. WASHINGTON, DC 1942 68 577-54-7538 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 28a-f show Examiner must be notified at 14 Yes 2 No Director WASHINGTON DC 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code with ö USA 20020 3416 23rd STREET S.E. 'natural", or items 23a Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. within 72 hours after 1 Never Married 2 Married BLACK 1 ☐ Yes 2 🛣 No Specify 2 3 ☐ Widowed 4 【 Divorced Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, Item Man Elementary/Secondary (0-12) College (1-4or 5+) 12TH SECURITY OFFICER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HATTIE WATSON ARTHUR S. PAYNE မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 2742 ALBERMARLE PLACE WALDORF, MARYLAND 20601 KENT E. PAYNE/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State RIVERDALE CREMATORY 12/31/2010 RIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Furery Service Licensee 12/2 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lauss (Lausace of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) physician Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Tectopic pregnancy Day in the past 12 months? Month Year 5 ☐ Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an page 2 s autopsy certificate 2 K No director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 21 No 2 ER/Outpatient 3 □ DOA Certification: To 1 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After Injury at Work? Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical соmpletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

within 2.

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records,

State

one)

29b. Signature and title of cortifier

30. Name and address of person who completed eaus

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32 Registrar's Signature

of death (Item 23a) (Type, Print)

mo

29c. License number

D005311

29d. Date signed (Month, Day, Year)

11711 LIVINGSTON ROAD FORT WASHINGTON, MARYLAND

20744

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death Month **Physician** Neuberge 22010 /Medical City, Town, or Location of Death Examiner Carro 9. Birthplace (State or Foreign Countingaryland 8. Date of Birth (Month Bay, Dec. 30, 7. Age (In vrs. last birthday **Funeral** 1934 Months Hours Min 1 M 2 F 75 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 No Sykesville Director Carrol1 Maryland 10g. Citizen of What Country? 10e. Street and Number USA 21784 #E-17710 OBrecht Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black White etc. 1 Yes 2 No If Yes, GiveN Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 N Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene, Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medica1 Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Erdman Edward J. Neuberger ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8456 Spring Showers Way, Ellicott City, MD 21043 Karl E. Reuss - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 12/29/2010 Parkville, Maryland Moreland Mem. Park 22. Name and Address of Facility Fleck Funeral Home, Inc. 21. Signature of Funeral Service Light 7601 Sandy Spring Road, Laurel, Maryland 20707 M01283 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome pf pregnancy
Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Manner of Dath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 1 □ Yes 2 □ No

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

the Maryland 28a-f show notified at

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

"natural", or items 23a or dical Examiner must be

signed by t funeral director, page 2 should certificate has After this hours after death.

uneral Director: A within 24 hours a

Medical Certification: To

5 Pending investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 29c. License numbe

MILLAMA

Obrecht Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. Fiells 31. Date filed (Month, Day, Year) **DEC 2 8 2010**

29b. Signature and title of certifier

22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 11: 72 SOL 2010 Marjorie M December Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 114 Roads End Lane Severna Park 9. Birthplace (State or Foreign Country)
Ohio 7. Age (In yrs. last birthday) 85 yrs. 8. Date of Birth (Month, Day, Yea Dec . 31 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours 1 □ M 2 🗓 F 007-26-1737 Dec. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant or other traumatic event, the Medical Examiner much because once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Severna Park MD Anne Arundel 1 🗆 Yes 2 🗶 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21146 USA 114 Roads End Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc ☐ Yes 2 🔀 No þ 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 ▼ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food Registered Dietitian 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Gladys Calvert Paul Zirkle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 514 Pine Tree Drive Severna Park, MD 21146 Greg Robinson / Son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec. 1 Burial 2 XCremation 3 Removal from State Baltimore, MD Metro Crematory, 4 ☐ Donation 5 ☐ Other (Specify) INC: 2010 22. Name and Address of Facility Barranco & Sons, 495 Ritchie Hwy, 21. Signature of Funeral Service Licensee Severna Park Funeral Home Severna Park, MD 21146 P.A. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ATTEVESE Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed by the attending physician and stached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? ate has been signed by the atte page 2 should be detached for Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No this certificate Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, it To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,

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DHMH 17 Rev 7/2009

Registrar

Medical

29a. Certifier

only one)

29b. Signature and tit

31. Date filed (Month, Day, Year)

eath (Item 23a) (Type, Print)

32. Registrar's Signature

Dahwood

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Gen Burnerad

29c License number

determined

Name and address of person who completed cause of

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ December 2010 Evelyn Melva Regan 11:44a.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dorchester General Hospital Cambridge Dorchester 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Oct. I1.1922 1 🗆 M 2 🗓 F Maryland 216-18-9877 88 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits death with the Maryland Director MD Dorchester Cambridge 1 🗆 Yes 2 🔀 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 16 Algonquin Road 21613 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give 2 **X** No 72 hours after Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🛣 No Specify. 3 🖾 Widowed 4 🗆 Divorced Completed Year or Dates 27 is marked other than "natural traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within Mental Hygiene. antique dealer antiques Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leroy Trautfelter Eleanor Germeroth permit. Page 1 and 2 should Department of Health and MI Important: If item 27 is mar any injury or other traumati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hurst R. Hessy p.r. 3500 Boston St. Suite 400, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Crematory of Delmarva 1/4/11 Delmar. DE 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END STAGE Physician/ CO? D disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PULMONALE Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an las l autopsy performed? Hospital or Attending Physician: The L24 hours after death. Funeral Director: After this certificate heted filled in by the funeral director, page 1 Yes 2 No Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 📝 No 1 🖪 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending 1 💆 Natural work? 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aft

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check з 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D69234 Mp of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address CAMBRIDGE 21613 MD BYRN STREET ERRABOLU 503 JEEVAN 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

JAN 0 5 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 26, 2010 ROBERTSON 11:42 P M PAULINE L. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Pocomoke City Hartley Hall Nursing Home If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 09/12/1918 Delaware 220-28-0730 92 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Pocomoke City Maryland Worcester 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 328 Winter Quarters Drive 21851 death 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, δ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 Widowed 4 Divorced "natural" Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker At Home 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ivy M. Culver Conrad O. Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1404 Princess Anne Lane - Pocomoke City, MD 21851 Robert G. Robertson, II (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Episcopal Cem. 20c. Location - City or Town, State injury or 1 X Burial 2 Cremation 3 Removal from State 12/31/2010 Pocomoke City, MD 4 Donation 5 Other (Specify) 21. Signatur 1 u S rvice 22. Name and Address of Facility Pradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, any Bradshaw, <u>зоё́ w.</u> Robert H. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final lerofis Physician disease or condition Medical resulting in death) Due to (or as a consequence) Examiner Sequentially list conditions, if any, leading to immediate Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 attending pl IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown 9 Unknown of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical funeral director, To Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury_at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Division 1 Tes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After t completed filled in by the funeral to the funeral filled in the fune

> ed cause of death #nem 23a) (Type, Print) ocourok 32. Registrar's Signa

DHMH 17 Rev 7/2009

State Registrar 29a, Certifier only one

29b. Signature and title of certifie

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 12/28

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Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 31 2 Year 0 Physician/ December Lawrence W. Rieder 1435 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Memorial Hospital at Talbot Easton Easton If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 220-07-3261 1 X M 2 🗆 F Months Davs Hours Min. (Month, Day, Year) 7/23/1918 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director MD Talbot Easton 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9023 High Banks Terrace 21601 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married should be filed within 72 hours after and Mental Hygiene.
is marked other than "natural", or Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 9 Master HVAC Technician Plumbina Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy
Important: If item 27 is marked oft any injury or other traumatic according 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William J.C. Rieder Elizabeth Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Cober - Daughter 31031 Dover Rd. Easton, MD 21601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/4/11 Meadowridge Mem. Pk. 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, MD fure of Funeral Service 22. Name and Address of Facility Harry H. Witzke's Family F.H. Ind. Signa M00845 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Gastrointestina disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown has been 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes 2 prior to completion of cause of death? : After this certificate has funeral director, page 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 읻 1 Dipatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred e Hospius. ∩ 24 hours after death. he Funeral Director: Afte 1 Natural 5 Pending 1 Yes Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou To the Funer completed file (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO053 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

Dennis

31. Date filed (Month, Day, Year)

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Easton, MD 21601

Street

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 22 2010 Physician/ DECEMBER 9:39 A M RANKIN SANDY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Min. 1 XM 2 - F Months Days Hours DECEMBER 4 WASHINGTON, DC 63 Director 579-62-2600 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location must be notified at Director 1 X Yes 2 No PRINCE GEORGE'S UPPER MARLBORO MD 10g. Citizen of What Country? 10f. Zip Code 5 10e. Street and Numbe 23a USA 20772 7403 GEORGIAN DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 0 þ 1 Never Married 2 X Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the GOVERNMENT POSTAL WORKER marked other Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental | Important: If item 27 is marked c any injury or other traumatic eve ပ္ CARLITA ASHBY SANDY C. RANKIN SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7403 GEORGIAN DRIVE UPPER MARLBORO, MARYLAND 20772 CAROLYN RANKIN/WIFE 20b. Place of Disposition (Name of Washington Nath Hace) Cem. 20c. Location - City or Town, State **Suitland** 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State ADELPHI , MARYLAND 12/30/2010 WASHINGTON Donation 5 D Other (Specify) J.B. JENKINS FUNERAL ROME, INC. ature of Funeral Service Licenses 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events ned by the attending physician and detached for use as the burial-transit Exam Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 - Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2 No 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 No death? 1 ☐ Yes 2 🖾 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital ၉ 1 🗌 Yes 2 No 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) s after deatn.
al Director: After this c 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State To the Hospital within 24 hours a To the Funeral C Medical 1 X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

2010

address of person who completed cause of death (Item 23a) (Type, Print) W(1)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

Please 1	Type or Print in	Black Indelible	Ink. Ensure	All Copies	Are Legible
	State of Marylar	nd / Department o	of Health and	Mental Hygid	ene

	•	For State State Registrar	•	partment of Health and ertificate of Death	Reg. 1	0010 :	1,
Physicia		1. Decedent's Name (First, Middle, Last) Hilda D. Rin	nggold		2. Date of Death Month 12	3. Time of Death 29 2010 12:48I	
Medic Examin		4a. Facility Name (if not institution, give street and num	mber)	4b. City, Town, or Location of Dea	ith 2	4c. County of Death	
/		Gensis Healthcare 5. Social Security Number 6. Sex		La Plata // If Under 1 Year If Under 24 Hr		Charles	
Funeral Director		5. Social Security Number 216-14-7113 G. Sex 1	7. Age (In yrs. last birthda) 94 Yrs.	Months Days Hours Mir		9. Birthplace (State or Forei Country) Maryland	ign
ath with the Maryland ms 23a or 28a-f show must be notified at	ctor	10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limi 1 XXYes 2 □	
ne Ma or 28a notif	Dire	Charles 10e. Street and Number	LaPlata	10f. Zip Code	100	Citizen of What Country?	140
with the s 23a cust be	Funeral Director	1 Magnolia Drive		20646	Tog. v	USA	
ter death or item miner m		11. Marital Status 12. Was Dec	edent Ever in U.S. 13 proces?	3. Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.	
saf ral", Exa	Completed by	3 Midowed 4 □ Divorced If Yes, Gi Year or D	ates.	1 ☐ Yes 2XXNo Specify:		Specify: White	
e filed within 72 hour tal Hygiene. ed other than "natu event, the Medical	mple	15. Decedent's Education (Specify only highest grade completed Elementary/Seconday (0-12) College ((Giv	cedent's Usual Occupation re kind of work done during most of wo DO NOT use retired)		Kind of Business Industry Ate of Maryland	
d withii lygiene ther th nt, the	Be Co	12th.		nistration Techni	N. 1411	alth Department	
be file ental H ked of	To B	17. Father's Name (First, Middle, Last) Francis Wm. Stringer			_{ame (First, Middle, Maide} liddlekoff	en Su <i>mame)</i>	
hould and Ma s mar iumati		19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Street and Number or R		or Town, State, Zip Code)	
and 2 s Health a tem 27 i		Francis Stringer/ Nephev		Unit D. Beekman	Pl. Washing	ton, D.C. 20009	
Page 1 nent of ant: If ii iry or o		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ Removal fron 4 □ Donation 5 □ Other (Specify)	State cemetery, c	position (Name of rematory or other place) ed Cemetery Jan		Location - City or Town, State altimore, Maryland	
permit. Departr Imports any inju		21. Signature of Funeral Service Licensee	-44	22. Name and Address of Facility H	untt Funera	1 Home	
		23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on e	caused the death. Do not e			Approximate Interval Between	
Physician/		Immediate Cause (Final disease or condition	Onset and Death				
Medical Examiner		resulting in death) Due to	(or as a consequence of):				
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rtificat ing ph e as th		IF FEMALE:					
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as t	Completed by Physician/N	23b. Was decedent pregnant 1 2c. If yes, ou		E Ctopic pregnancy Other (specify)		23d. Date of delivery Month Day Year	
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The law rate has boage 2 sk	omple	Hypertension			24a. Was an autopsy performed?		le of
sian: J ertifica ctor, p	Be (25. Was case referred to medical examiner?		26. Place of Death (Ch		110	
Physic this ce al dire	၉	1 Yes 2 X No	Inpatient 2 ER/Outpat		Home 5 Residence		
nding F tth. : After e funer	cate	27. Manner of Death 1 1 Natural 5 Pending 2 Accident Investigation	of injury 28b. Time injury injury		28d. Describe how inju	jury occurred	
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Hospita 24 hours Funeral eted filled	Medical	(Check 2 Medical Examiner: On the ba	sis of examination and/or inv		d at the time, date and place	ice, and due to the cause(s) and manner st	tated.
To the within To the comply	Σ	only one) 3 L Certifying Nurse Practioner: 29b. Signature and title of certifier	2 /	e, death occurred at the time, date and p 29c. License number		pate signed (Month, Day, Year)	
		Will of the	PHYSICIA	<u>n</u>	10	430/2010	
NB10		30. Name and address oberson who completed cau William J. Crittenden 7	350 Van Duce	n Rd Sta 350 Ia	י חדיבו את 20	707	
Stat		31. Date filed (Month, Day, Year) 32. F	egistrar's Signature	hall	GLCI, FID ZU	101	
Registra		JAN 0 7 2011 4	in b				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death December 30, 2010 Physician/ Pearl Salmon Ray-Miller 1:15 P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Georges 1519 Birchwood Drive Oxon Hill Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth 7. Age (In vrs. last birthday **Funeral** Months Days Hours Min 1 🗆 M 2 🗶 F July 14, 1930 Director 034-22-4335 80 Massachusetts Usual Residence of Decedent 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director Prince Georges Oxon Hill 1X Yes 2 No Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1519 Birchwood Drive 20745 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Specify: Black 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) U. S. Department of Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade **Executive Assistant** Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Salmon Lilly Rutherford Leroy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Renee Ray (Daughter) 1519 Birchwood Drive; Oxon Hill, Maryland 20745 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan. 8. 2011 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 21. Signature of Funeral Service Lig 22 Name and Address of Facility R. N. Horton Company Morticians, Inc.; 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications in at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Colon Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of) burial-transi Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypotension cate has been sig page 2 should b 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital Other: ပ 1 Tes 2 **X**No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 X Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of ce

Ali Rahimian, M.D. 32. Registrer's Signature 29d. Date signed (Month, Day, Year)

January

3, 2011

29c. License number

D0052999

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:28A /Medical Dec 24 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Genesis Health Care-5. Social Security Number 6. Sex Faston er i Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Talbot 8. Birthplace (State or Foreign The Pines If Under **Funeral** 7. Age (In yrs. last birthday) 219-60-1211 Usual Residence of Decedent 1 □ M 2 1 F Months Yrs. 31, Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show 1 Wes 2 No Director brida 10f. Zip Cede 10e. Street and Number 10g. Citizen of What Country? US 1613 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 ₺No Specify: Black 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Mona Sheppard Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) ttend Group ant is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 95 Unionville permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. Rd. Ea D. 21601 ichelle Ston 4a м мо по 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Easton, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Home, Henry Funeral Home, Henry Washington Str 21. Signature of Funeral Service Licensee Home, P. A. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused 1. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ocarditis /Medical Examiner Weeks erenna Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? ignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Medical Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Division of Vital pertansion 2 🗆 No □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death

1 ☐ Natural

2 ☐ Accident 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 1010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

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SO WAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** 2010 tanley Dec. hello Warre 23 : 55 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or location of Death Examiner Mallard BayNursing Center Dorchester (In yrs. last birthday, Birthplace (State or Foreign Country) Sex 102 M 2□ F Days Hours 14-12-6181 Months JUne **Director** Maryland Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show the Medical Examinat must be notified at 1 Ves 2 No Director Dorchester 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral burn 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 **N**o 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify Specify: Black þ 3 Widowed 4 Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SeafoodIndustr rocessor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be 1 Health and Mental Stanley Davis 401 OMMY Pages 1 and 2 should 2 en 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau Drive Apt. 315 Cambridge, MD. 21613 Doris Date 20c. Location - City of Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Salem, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Acility
Henry Funeral
5/0 Washington 21. Signature of Funeral Service Licenses HOME, 23a. Part / Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. bridge, MD.21613 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stare Dementiz **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy for 1 in the past 12 months? Month Day Year 5 ☐ Other (specify) I ☐Yes 2 ☐ No the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 No 1 ☐ Yes 2 400 1 □Yes Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the I within 2 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2. Registrar's Signature

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31. Date filed (Month, Day, Year)

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CAMBRIBLE MD 2/6/3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12 Shreeves 4:10 P=M Georgia 24 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Norsing & Renab center Pocomoke Hall City Worcester 7. Age (In yrs. last birthday) Yrs. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Mary land 6. Sex **Funeral** 1 🗆 M 2 🅦 F Days (Month, Day, **Director** 215-12-6737 July al Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Crisfield Somerset 1 X Yes 2 No mary land 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21817 U.S.A. Somers 326 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Seafood Industry Laborer 11th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked ot Sr. Sterling Edith Torney Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Blue 2436 Chest nut Ciacle, Princess Anne modalses Daughter Kay 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State permit. Page Department of Important: If any injury or 11111 Westover md 4 Donation 5 Other (Specify) John Wesley U. M.C. Cemetery! Ward F.H 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. Anthony a. Wark 30639 Hampden Ave Princess Anne, md 71857 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ DEMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner FAILURE THRIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events resulting in death) Last burial-trai Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 the IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death
Unknown ed by the a 1 Yes 2 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2. No 1 Yes Division of Vital hin 24 hours after death.

the Funeral Director: After this certific

mpleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 \(\text{Yes} 2 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title o 29d. Date signed (Month. Day. Year. 12/28/2010 0 62172 MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARAD POCOMOKE CITY JATUAL 1604 MARKET ST MD 21851 , MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

JAN 03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December JACKIE W. STERLING 2010 9:20 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 300 Belt Street Worcester Snow Hill If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 X M 2 🗆 F Months Days Hours Maryland 219-46-3849 63 Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City. Town or Location traumatic event, the Medical Examiner must be notified at Director 10d, Inside City Limits Maryland Worcester Snow Hill 1 X Yes 2 No 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 300 Belt Street 21863 U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 X Yes 2 No 1967-Black, White, etc. þ ò 1 Never Married 2 X Married 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Specify: White 3 Divorced 4 Divorced 1969 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Wicomico County Be Department of Health and Mental H Important: If fine 27 is marked oft, any injury or other traumatic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jackie Alonza Sterling Myrtle Louise Bundick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Emily Sterling (Wife) 300 Belt Sreet - Snow Hill, MD 21863 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Crematory of Delmarva 12/21/2010 4 ☐ Donation 5 ☐ Other (Specify) Delmar, DE 22. Name and Address of Facility
Bradshaw & Sons Funeral Home
306 W. Main St. - Crisfield. Bradehaw, Robert Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause (Disease or linjury Dusty fores are assessment of Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? detached for Month Dav Year Pregnant at time of death 2 No the g | Linknown 9 Unknown as been signed by 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 TYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an this certificate has page perform 1 🗌 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of D ath 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending work? death. 2 🗌 No after death Accident Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by Homicide determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hodical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one)

DHMH 17 Rev 7/2009

State Registrar

29b.

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ ALICE M. SHEPHERD 01:57 M Decembia 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Nicomico Poninsula ilisb Regional Medical Conten Age (In yrs. last birthday) 88 Yrs If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. (Month, Day, Yea 1 □ M 2 🖫 F Months Hours 176 18 4768 **Director** New Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 🗆 Yes 2 📮 No Maryland Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Funeral 23a 7 Edgewood Drive 21811 U.S.A. Il Hygiene. I other than "natural", or items ' vent, the Medical Examiner mu within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Account Secretary Banking Be other traumatic event, permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Estelle Weatherwax Malachi McGinnis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John Alan Shepherd Edgewood Dr. Berlin, MD 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State First State Crema: 12/30/10 Millsboro, 4 Donation 5 Other (Specify) Signature of Functial Service Licensee 22. Name and Address of Facility 108 William St. The Burbage Funeral Home Berlin, MD mayo Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ COPD disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Dementis zheimer's Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filied in by the funeral director, page 2 should be detached for use as the burial-transit Cancer that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 W No
9 ☐ Unknown Month Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 1 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: ✓ Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier

State Registrar

DH 3+1

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

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Salisbury.

106 Mil fordST. # 504B,

32 Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3

Babula Das

31. Date filed (Month, Day, Year)

JAN 0 3 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G911 1/26/2011 Jh
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 4:15A M Physician/ Dec Helen 30 2010 Shade Rose Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner St. Mary's Mechanicsville 26195 Independence Drive 8. Date of Birth g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 6. Sex **Funeral** Country) MD Days (Month, Day, Min Yea 1 □ M 2 🏝 F 84 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". or item any injury or other traumatic event. 10c. City, Town or Location 10b. County 10a. State Director 1 X Yes 2 No st. Mechanicsville MD Mary's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 26195 Independence Drive 20659 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 1 Never Married 2 Married ☐ Yes 2 X No Completed by Specify: Black 1 ☐ Yes 2 🔀 No If Yes, Give 3X Widowed 4 ☐ Divorced Year or Dates 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Private Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Millie Young William H. Mills 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6808 Northgate Pkwy.Clinton,MD 20735 Agnes Taylor/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 1 🔀 Burial 2 🗌 Cremation 3 🗍 Removal from State Sacred Heart Cem. Jan.5,2011 Bushwood,MD 4 Donation 5 Other (Specify) 22. Name and Address of FacilityBriscoe-Tonic Funeral Home Signature of Funeral Service Licer 2294 Old Washington Rd.Waldorf, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. the mode of dying, such as Onset and Death ENA Immediate Cause (Final W Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): HEROSCLEROTIS Examiner ANCE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine the attending physician and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day page 2 should be detached for Pregnant at time of death 9 | Inknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 prior to completion of cause of death? certificate has 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, To Be examiner Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending 2 🗌 No 1 Tes within 24 hours after death To the Funeral Director, A Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29d. Date signed (Month, Day, 29c. License number 29b. Signature ar n who completed o 30 Na e and address of pers

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State

Registrar

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Registrar's Signatu

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend 23a per med cert G912 2/24/11 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 26, Physician/ Geraldine Smoot Month 1:40 PM December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Laurel Regional Hospital Prince George aure 5. Social Security Number 8. Date of Birth
AMonth 12, 1926 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Hours 1 🗆 M 2 😾 F Marviland Director 219-22-7630 Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. and the strain and Mental Hyglene. The straint if items 23a or 28a-f sho and if item 27 is marked of other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10b, County 10c, City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Beltsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3008 Chapel View Drive 20705 United States . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: 3 X Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter Clifton Nicholas Louisa Kuchling Emma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne E. Smoot -son 104 Harvard Avenue Stratford, New Jersey 08084 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition
1 □ Burial 2 X Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 12/28/2010 Alexandria, Virginia 21. Signature of Funeral Service (Icensee Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Ph sician/ Septic Shock disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Multi-organ Failure Sequentially list conditions, Examine it any reading to in mediate cause. Enter Underlying Cause (Disease or linjury that initiated events Acute Respiratory the attending physician and hed for use as the burial-transit Failure that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Peritonitis & Metabolic Acidosis Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death signed by the a Id be detached for 1 ☐ Yes 2 ¥ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Physician: The law requires 1 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has I performed? Yes 2 No 2 X No 1 Yes B B 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Hospital 2 **X** No Other: မြ 1 Tes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the caus Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practioner T. the Sest of my knowledge, death unnormed at the time, date and place, and due to the cause(e) and many or as state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D00012962 December 28, 2010 Laurel Regional Hospital 30. Name and agaress of person who completed cause of death (Item 23a) (Type, Print) Lee-Llacer, MD Zorayda Dusen Road 7300 Van 31. Date filed (Month, Day, Year) JAN 03 Registrar

1	State Registrar		Cei	rtificate of	Death			Reg. N	402 U	10	428	363
	1. Decedent's Name (First, Middle, Last)						2. Date of De		Day	Voar	3. Time of	Death
L	Dorothy Louise Sheets						Decemb	er	29 20	<u>o ľor</u>	2:00	АМ
ľ	4a. Facility Name (if not institution, give street and num	nber)		4b. City, Town,				4	c. County		_	
ļ	2140 Woodbine Road 5. Social Security Number 6. Sex	7. Age (In yrs. las	st hirthday)	If Under 1 Year	dbine	r 24 Hrs.	8. Date of Bir	th		Howa	hnlace (State o	r Foreign
	220-28-7367 1 □ M 2 🗓 F		94 Yrs.	Months Days		Min.	Nov 2	y, Year	916	Cou	intry) Illir	nois
h	Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Lo	cation							10d. Inside Cit	tv Limits
ı	Maryland Howard		Woodbi									2 X No
- 1-	10e. Street and Number			10f. Zip Code			I	10g. (Citizen of	What Co	untry?	
١	2140 Woodbine Road			2179	97				Unit	ed S	tates	
Ī	11. Marital Status 12. Was Dece Armed Fo	dent Ever in U.S.	13. \	Was Decedent of I	Hispanic O	rigin? (Spe	cify Yes or No-				ican Indian,	
1	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, Giv Year or Da	2 X No e		1 ☐ Yes 2 X N			i iiodiii, otoly		Specify	ck, White :	White	
	15. Decedent's Education (Specify only highest grade completed)		(Give	dent's Usual Occu kind of work done	during mo	st of worki	ng	16b.	Kind of B	usiness I	ndustry	
	Elementary/Seconday (0-12) College (1	-4 or 5+)		O NOT use retired Technic	,				NIH	į.		
ŀ	17. Father's Name (First, Middle, Last)			1001111110		her's Name	e (First, Middle,	Maide				
١	Brack Clark Berry					Grac	e Reyno	olds	5			
ľ	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Stree	and Numb	oer or Rura	l Route Numbe	r, City	or Town, S	State, Zip	Code)	
ļ	Juanita Sweadner/Daught			Woodbine	Roa		odbine				Town, State	
ľ	1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State ce	metery, cren	natory or other pla n Pres.					rnes	,		
İ	21. Signature of Funeral Service Licensee		22	2. Name and Addr	ess of Faci	lity	DeVo1	Fur				
+	23a. Part 1. Enter the disease, or complications that of	MO12		E. Deen					ersbu	irg,	Approximate	
I	shock, or heart failure. List only one cause on ea	ch line.		er the mode of dyr	ng, soon a	s cardiac o	respiratory ar	1631,			Interval Bet	ween
	disease or condition Card	iomyopa or as a conseque									Months	
ı	Valv	ular He		Lsease							Years	
١	Sequentially list conditions.	or as a conseque				•						
١	Cause (Disease or iinjury that initiated events c											
	resulting in death) Last Due to (or as a conseque	ence ot):									
	d											
	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, out	come of pregnan Birth 2 🗌 Fetal	су						23d. Da	ate of d eli	iverv	
	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 1 ☐ Live 4 ☐ Pregi	nant at time of de	death 3 L eath 5 C	Lectopic pregnar Other (specify)	icy					onth		Year
1	Part II. Other significant conditions contributing to d	eath but not resu	Iting in the u	inderlying cause o	iven in Par	t I.	23e, Did t	obacco	use cont	ribute to	the cause of de	eath?
١											obably 4 💢 l	
١							24a. Was		24b.	Were aut	opsy findings a	available
ľ							auto perfo	psy rmed? 2 🔼	No	death?	completion of c	ause or
I	25. Was case referred to medical examiner?				lace of De	ath (Check						
L	1 Yes 2 X No Hospital:	Inpatient 2 D		nt 3 LL DOA			me 5 🗓 Resi				fy)	
ľ	27. Manner of Death 1 🕅 Natural 5 🗆 Pending 2 🗋 Accident Investigation	of injury h, Day, Year)	28b. Time of injury	wor		- 1	28d. Describe I	now inju	ury occurr	red		
	3 Suicide 6 Could not be 28e. Place	of Injury - At honing, etc. (Specify)	ne, farm, stre	eet, factory, office			28f, Location (\$ City or Tov			er or Run	al Route Numb	er,
ŀ	29a. Certifier 1 X Certifying Physician: To the b											
L	(Check 2 Medical Examiner: On the bas only one) 3 Certifying Nurse Practioner:			death occurred at t	he time, da			e cause	e(s) and ma	anner as	stated.	nner stated
ľ	29b. Signature and title of cortifier)		29c. Licens							, Day, Year)	
-	CO. Name and addition	20141-11-11	20.0\ 77	D643	95			ре	cembe	er 30	2010	
ľ	30. Name and address of person who completed caus Danielle Doberman, MD,	6701 N.	Char	les St.,	Ste.	4105	, Balt	imo	re, M	1D 21	1204	
3		egistrar's Signatu		w								
4	The state of the s	The same of										

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Paul Howard SCHAFFER 20/6 7 Dec 28 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Shady Grove Adventist Hospital Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Apr. 12, 1943 1 M 2 D F Days Hours 036-28-7891 67 Rhode Island Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified of once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Gaithersburg 1 ☐ Yes 2 🕅 No 10e. Street and Number 10g. Citizen of What Country? 103 Swarthmore Avenue 20877 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: Completed white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) EPA Administrator Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Isadore George Schaffer Betty Shuster 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 424 West End Ave., #8G, New York, NY 10024 Lauren Coulston, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) <u>Judean Memorial Gardehs 12/30/10</u> Olney, MD Sign sure of Faneral Seok e Licensee Torchinsky Hebrew Funeral Home 101008 <u> 254 Carroll St., NW. Washington, DC</u> 23a. Part 1[Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** ECYSTITI (Sequentially list conditions, Examine ending physician and or use as the burial-transit if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy To the Hospital or Attending Physician: The l within 24 hours after death. To the Funeral Director; After this certificate h performed Yes 2 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my criminal death. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certhying Nurse Practionary T. the best of my kind will do death occurred at the time, date and place, and due to the cause(c) and internet stated (Check only on 29b. Signature and title of certifier 29c. License number 29453 Loudell 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKVILLE MD 20850 SHADY ALAN S- CHANALEGUD ROVE RD 31. Date filed (Month, Day, Year) State **JAN 03** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Virginia Garner Saravia 20 Î 23, 9:15 a.M December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 8. Date of Birth **Funeral** Days Hours Min Feb. 9, Year 1950 **Director** 60 215-60-7527 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MDMontgomery Takoma Park 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8027 Glenside Drive 20912 United States permit. Page 1 and 2 should be filed within 72 hours after death of Department of Health and Mental Hyglene.
Important: I fitem 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Thompson Vera Roth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rene Saravia (husband) 8027 Glenside Dr. Takoma Park, Maryland 20912 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec Date 30. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2010 22. Name and Address of Facility Rapp Funeral & Cremation Service M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or sequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month
1 Yes 2 No
9 Unknown signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica æ 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2-1 No Other: Certificate: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Takoma MD20912 30 7600

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN 0

20

Registrar's Signature

Tyrone Wendell Shaw

10-09959 UNK UNK Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

JNK UNK	State of Maryland / D	Department of t Certificate of L			2010 g. No.	42866
Physician/ Medical Examine	Decedent's Name (First, Middle,Last)	naw		2. Date of Death	Day Year	3. Time of Death 2345 hrs
Medical Examine	4a. Facility Name (if not institution, give street and number)		City, Town, or Location of Death	December:	24, 2010 4c. County of Death	2345 IIIS
	PG Hospital Center		Cheverly		Prince George	
Funeral Director			If Under 1 Year If Under 24Hrs Months Days Hours Min.		(MM/DD/YYYY) 9. Birt Foreig 5,1975	hplace (State or nWashington, untry) D. C.
k	Usual Residence of Decedent	- C' - T		1 5	, , , , ,	
I cow any	Dist. 1 - 5 C - 1 1 1	c. City, Town or Location Washing				10d. Inside City Limits 1 X Yes 2 No
the Maryland a or 28a-f show	10e. Street and Number		Of. Zip Code	100	g. Citizen of What Coun	
the M is or 2 biffied	4815 "B" Street, S. E.		20019		United Sta	ites
r death with or items 23 must be no	11. Marital Status 1 Never Married 2 Married Armed Forces?	If Yes,	Decedent of Hispanic Origin? (Sp., specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Americ White, etc.	can Indian, Black,
ter dea	1 Yes 2 A	No	es 2X No specify:		Specify: B1	ack
ours aft atural ramine	15. Decedent's Education (Specity only highest grade complet	ted) 16a. Decedent's	Usual Occupation (Give kind of v		16b. Kind of Business/Ir	ndustry
36 in 72 h han "n lical E	Elementary/Secondary (0-12) College (1-4 or 5+) 9th grade	during most	of working life. DO NOT use reti	rea)	Non-	
5-0036 ed within 72 hour bygeine. other than "natu the Medical Exan	17. Father's Name (First, Middle, Last)		None 18.Mother's Name	(First, Middle, Ma	None	
De fill be fil	Johnny Shaw		Thomas	ine B	utler	
MD 21 12 should th and Me 27 is ma umatic ev	19a. Informant's Name/Relationship (Type, Print) (Mothe Thomasine Butler Burwick		ddress (Street and Number or F B" Street, S.E.			
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: If item 27 is m injury or other traumatic. To	20a. Method of Disposition	20b. Place of Dispositio	n (Name of cemetery,	Date	20c. Location - City or	
Baltimore, permit. Pages I as Department of He Important: If ite	1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	Heritage Mo	emorial Cemeter	.3,2011	Waldorf,Ma	rvland
Salti ermit. Jepartır mporta	21 Signature of Funeral Pervice Licensee	22, Nam	ne and Address of Facility ${f R}$. ${f I}$. Horton	n Company M	orticians,
Physician	23a. Part I. Enter the disease, or complications that caused the		;600 Kennedy St			On, D. C. 2001 Approximate Interval
/Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Blunt Force	e Injuries				Between Onset and Death
Examiner	or condition resulting in death) Due to (or as a conseque	ence of):				
Ē	Sequentially list conditions, if any, leading to immediate Due to (or as a conseque	ence of):				
ted Insit Examiner	cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a conseque	ence of):				-
cecuted 1 and - transit	d					
<u>≅. ≅ ≅ ≅</u>	UNPENDED					
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi hystician/Medical E)	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of 1 Live birth	2 Fetal	death 3 Ectopic pregna	ncy	23d. Date of delivery Month Da	ay Year
b. Box 6876 the death certificate the attending phy the attending phyched for use as the Physician/M	4 Pregnant at time 1 Yes 2 No 9 Unknown 9 Unknown	e of death 5 Other	(Specify)			
. 4 .4 7		t not resulting in the unde	erlying cause given in Part I.	23e. Did toba	acco use contribute to the	he cause of death?
S, P.O uires that the signed by de detac					2 ✓ No 3 Proba	ably 4 Unknown
Records, The law requires ficate has been signage 2 should be Completed				24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
tal Rections: The legistrate legi				perform 1 ✓ Yes 2		2 No
of Vital Records, ag Physician: The law require ther this certificate has been si meral director, page 2 should be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatient 3	26.Place of Death (Check of DoA Other Nursing		esidence 6 Other:	= 3
ding Ph ding Ph After tl funeral	27. Manner of Death 28a. Date of Injury (Month, Day, Xear)	28b. Time of Injur	·	28d. Describe hor Pedestrian str		
Sion Attend death. ector: by the f	2 Accident Investigation	2245 hrs	1 Yes 2 ▼ No			
Division of spiral or Attending nours after death. The real Director: After filled in by the fune Certification:	Suicide Could not be	- At home, farm, street, fa Road / Highway		or Town, Stat	eet and Number or Rura te) ay and Branch Avenu	
0 - 5 2	29a. Certifier 1 Certifying Physician: To the best of my know	owledge, death occurred	at the time, date and place, and	due to the cause(s) and manner as state	d.
To the Hos within 24 h To the Fun completely	one) 2 Medical Examiner: On the basis of examinat and manner stated.	ition and/or investigation,				
≥	29b. Signature and filte of certifier	no to	29c. License number O.C.M.E.		29d. Date signed (Moni December 25, 20	· ·
	30. Name and address of person who completed cause of death	(Item 23a)	1			
- 3	Russell Alexander MD. Assistant Medical E	Examiner 111 Pe	enn Street, Baltimore, MD	21201		
State	31. Date filed (Month, Day, Year) 32. Registrar's Si	ignature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Carlota Samuel-Cates 2010 1600 HrsM December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Woodside Center Silver Spring 9. Birthplace (State or Foreign Country) **South** Social Security Number If Under 1 Year If Under 24 Hrs 1934 12, 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 1 🗆 M 2 🛣 F Months Hours October 217-70-8912 76 **Director** Chile, America Usual Residence of Decedent 28a-f show 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location must be notified at Director 1 X Yes 2 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? items 23a Funeral 20906 4213 Round Hill Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or ģ 1 Never Married 2 X Married 1 Yes 2 X No If Yes, Give 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Latino 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic (Specify only highest grade completed) George Washington Elementary/Seconday (0-12) College (1-4 or 5+) University Hospital 10th grade Housekeeper Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gumesida Alberta Samue1 Sanchez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Ray Cates (Husband) 4213 Round Hill Road; Silver Spring, Maryland 20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec.31, cemetery, crematory or other place) 1 🛣 Burial 2 🗆 Cremation 3 🗆 Removal from State Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Signatury Funeral Sevice Ligense 22. Name and Address of Facility R. N. Horton Company Morticians, Jano Inc.: 600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ minutes Pulmonary Edema disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner weeks Anasarca Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Adenocarcinoma months ending physician and use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 Yes 2 X No Month Day Year Pregnant at time of death g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 K No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

State Registrar

completed

within 2

29a. Certifier

29b. Signature and title of certifi

Tanyech Walford, M.D.; 9101 Second Avenue; Silver Spring, Maryland 20910 32. Registrar JAN 0 4 2011

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

ٌ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

30, 2010

December

29c. License numbe

D68583

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		rtificate of			Reg. No.	0	12868
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day	Year	3. Time of Death
100	/Medi	cal	ROSABELLE SOMERS T 4a. Facility Name (If not institution, give street and number)	YLER	4b. City, Town, o	r Location of Death	Decembe	4c. County	2010 of Death	7:55 A M
1	Examir	ier	5179 S. Pomfrett Road		Crisf				rset	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 06/01/1	y, Year)	9. Birthp Coun Mary	lace (State or Foreign htry) Land
	rland ow		Usual Residence of Decedent 10a. State 10b. County 10c. City	y, Town or Lo					1	0d. Inside City Limits
	a-f sh	ctor	Maryland Somerset	Cr	isfield					1 □Yes 2X No
	vith the	Dire	10e. Street and Number		10f. Zip Code			10g. Citizen of		itry?
	ms 23s	Funeral Director	5179 S. Pomfrett Road 11. Marital Status 12. Was Decedent Ever in U.S.	S. 13. '	Was Decedent of H		pecify Yes or No-		S.A.	an Indian,
9600	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinat must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married I ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 □ Yes 2 X No	an, Mexican, Puerto	Rican, etc.)	Specif	ck, White, 6 fy: Whi	te
15-(n 72 h "natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	king	16b. Kind of B	usiness/Ind	dustry
212	d withi giene. er than	mo.	Elementary/Secondary (0-12) College (1-4or 5+)	Teach		-,		Somerse	t Co.	. Schools
nd	be file ital Hy d othe event,	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	,	Maiden Surnar	ne)	
ryla	hould nd Mer marke matic	ဂ္	Clifton Somers 19a. Informant's Name/Relationship (Type. Print)	T 19b Mailiu	ng Address (Street		n Evans	er City or Town	State Zir	(Code)
Ma	alth ar 27 is		Clifton Miles Tyler (Son)	T	Old Pond				3065	0000)
Baltimore, Maryland 21215-0036	Pages 1 and the south of the south of the south or other sury or other s		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	lace of Dispo emetery, cren nyridge	sition (Name of natory or other place Memorial P	erk 12/	Date 30/2010	20c. Location Crisfi	•	
Balti	permit. Departr Importa any Inju		21. Signature Françai Service Lio	Br	2. Name and Addre cadshaw & 06 W. Mai	ss of Facility	eral Ho	me d, MD	21817	7
Е			Robert H. Brachaw, Jr. 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one case on each line.				1000		21017	Approximate Interval-Between
	Physician		Immediate Cause (Final disease or condition	which	Careri	Wayen,	lar E	A's. (Aciv	Ortset and Death
r'	/Medical Examiner		resulting in death) Due to (or as a consequ	uence of):						
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	делсе of).			_			
	ecuted and -transii	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
68760,	rtificate be executed ng physician and as the burial-transit		Due to (or as a consequence of the consequence of t	zerice di).						
89	ertifica ing ph	Medical	IF FEMALE:							
). Box	e death cel he aftendir led for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 23c. If yes, outcome of pregnant in the past 12 months? 4 □ Pregnant at time of d	Ideath 3	☐ Ectopic pregnand ☐ Other (specify) _	У			ate of delive onth	ery Day Year
P.O.	ires that the de signed by the a be detached t		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use con	tribute to the	ne cause of death?
rds	quires en sign uld be	ed by					1 🗆 Y	res 2 No	3 ☐ Prob	oably 4 Unknown
eco	ie law require has been si ge 2 should t	Completed					24a. Was		Were auto	psy findings available mpletion of cause of
Division of Vital Records,	i: The						perfo	rmed?	death? 1 □ Yes	2 🗆 No
ξ	ysicial s certi directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 🗆 DOA Oth	er: 4 \(\sum \) Nursing H	th <i>(Check only o</i> ome 5 Resid	P .	her (Snecii	5/)
n o	ng Phy fter thi ineral (J:uc	27. Manner of Death 1 Natural 5 □ Pending (Month, Day, Year)	28b. Time of Injury			28d. Describe h			<i>y</i> /
sio	ttendi death. ttor: A	icati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At ho	ome form etc		Yes 2 □No	29f Location (6	Street and Num	hos as Dur	al Pauta Number
<u>></u>	al or A s after il Direc	Certification: To	4 ☐ Homicide determined building, etc. (Specify	y)	eet, factory, office		City or Tow		per or Hura	al Route Number,
	To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death. To the Funeral Director: After this certificate has been signed by the aftendir completely filled in by the funeral director, page 2 should be detached for use	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my known and manner stated.							
	To the To the Committee of the Committee	Ň	29b. Signature and the of certifier	MI	29c. Licens	e number	22	29d. Date signe		
	XCD		30. Name and address of person who completed cause of death (Item	1 23a) (Type,	Print)	0 5	1851	i		
	Sta		31. Date filed (Month, Day, Year) DEC 28 2010 32. Registrar's Signar	ture			/_			
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DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and	Mental Hy	giene		
			= State Registrar Certificate of Death	1	Reg. No.		12869
	Physicia Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Helen Frances Tyler	2. Date of De Month	Day	Year	3. Time of Death
	Examin		4a. Facility Name (if not institution, give street and number) Coastal Hospice at the Lake 3 alisbu	h	4c. County	of Death	nico
	Funeral Director		5. Social Security Number 026-14-3396 6. Sex 1		th		lace (State or Foreign
~	3		Usual Residence of Decedent				
	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show sumatic event, the Medical Examiner must be notified at	Funeral Director	10a. State 10b. County 10c. City, Town or Location Berlin			1	0d. Inside City Limits 1 1 Yes 2 □ No
	or 28	Dir	10e. Street and Number 10f. Zip Code		10g. Citizen of V	What Coun	
	s 23a	eral	24 Lord Guy Terrace 21811		USA	Wild Godin	шу.
	death item ner m		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	14. Rac	e - Americ	
030	s after ral", or Exami	Completed by	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ XNo 1 ☐ Yes 2 ☐ XNo 1 ☐ Yes 2 ☐ XNo 1 ☐ Yes 2 ☐ XNo Specify: Year or Dates,			Whi	
င္	2 hour "natu dical	plet	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of wo.	rkina	16b. Kind of Bu	usiness Inc	dustry
127	ithin 7; ene. • than he Me	Som	Elementary/Seconday (0-12) College (1-4 or 5+) College (1-4 or 5+) Telephone Operator	•	Commur	nica	tions
ō Zi	led will Hygir	Be (me (First, Middle,	<u> </u>		
Maryland 21215-0036	lid be fi Menta larked atic ev	잍	Carl Tyler Gertru	ide Don	ahue		
	permit. Page 1 and 2 should be I Department of Health and Ments Important: If item 27 is marked any injury or other traumatic enonce.		19a. Informant's Name/Relationship (Type, Print) Margaret Mazzilli/sister 72 Crest Haven Dri				
saltimore,	Page 1 ar nent of He nt: If iter ny or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cernetery, crematory or other place) First State Crem 1/4	Date	20c. Location -	•	
balt	permit. F Departm Importa any inju	1 12	21. Signature of The Service Licensee 22. Name and Address of Facility But 108 William St.	ırbaqe	Funeral	l Ho	
ľ			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			1011	Approximate
4	hysician	6 48	shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a RRNAL CARCINO MA				Interval Between Onset and Death
	Medical Examiner	L	Due to (or as a consequence of):				
	rted	amine	Sequentially list conditions, if any, leading to immediate cause. Line Unidentying Cause (Disease or linjury				
	so that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	dical Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):				
8	icate g phys	ledi					
00 X	r use a	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Dat	te of delive	ery
7. DOX	the death	Physician/Me	in the past 12 menths? 1 Yes 2 No 9 Unknown Unknown County Cou		Mo	nth	Day Year
ָר, קי רי	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Ď	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	<u> </u>		e cause of death?
SCOLUS,	law required has been ge 2 shou	Completed		24a. Was autop	osy F	Vere autop prior to cor leath?	osy findings available inpletion of cause of
č	n: The ficate or, pag	ပ္ပို	25. Was case referred to medical 26. Place of Death (Cha	1 \(\text{Yes}	2 No 1	Yes	2/ ⊆ No
2	ysicia s cert direct	To Be	examiner?	dome 5 Resid	lanca & Potha	r (Speciful	HOSPICIZ
5	ng Ph		27. Mapper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury at work?		ow injury occurre		(100)
	ttendi death stor: A / the fi	Certificate:	2 \(\text{Accident} \) Investigation \(\text{M} \) 1 \(\text{Yes} \) 2 \(\text{No} \) No	001 1 11 15			
	tal or A rs after al Direc ed in by		4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Street and Numbern, State)	er or Rural	Route Number,
;	the Hospi nin 24 hou the Funer	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, a death occured at the time, date and place, a construction of the death occurred only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place and place are constructed only one)	at the time, date a	nd place, and due	to the cau	se(s) and manner stated.
	Voit Con		29b. Signature and time of certifier 29c. License number		29d. Date signed	1 (Month, E	**
	10 E	5	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHUMAN WARES POBOL 1733 SAUSBUL	W L	up 2	-180	2
	State Registra	~	31. Date filed (Month, Day, Year) JAN 0 3 2011 32. Registrar's Signature				
			personal per				

		For	State of Marylar				Mental Hy	giene	10	100	70
		State Registrar		Cert	ificate of L	Death		Reg. No.	IU	4 4 8	10
Physic	ian/	1. Decedent's Name (First, Middle, Last Esther Leeth T	,				2. Date of Dea	r 2 ⁹ , 20	Year	3. Time of D	
Med	ical	4a. Facility Name (if not institution, give	urner							2:07 a	M
Exam	iner	2900 N. Leisure			4b. City, Town, or 4 Silve			4c. County Mon t	of Death	ry	
Funera		Social Security Number 6. Se			If Under 1 Year Months Days				9. Birth	place (State or F	oreign
Directo	1	378-14-0301	M 2 3 x F 92	Yrs.	Months Days	Hours Mir	Aug. 3	1, 1918	Cour	place (State or F	
nd how at	5	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Loca	ation			-	1	I 0d. Inside City	Limits
laryla 3a-f s ified	ect	MD Mont	gomery	″ 511v	er Sprin					1 Yes 2	
or 28	흡	10e. Street and Number	gomery	DIIV	10f. Zip Code	ig	T	10g. Citizen of V	Vhat Cour	ntry?	
with s 23a ust b	Funeral Director	2900 N. Leisure	World Blvd.,	Apt. 3	J. 4	2090	6	USA			
death item	F.	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (Specify Yes or No-			an Indian,	
36 after I", or xamit	Completed by	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give		☐ Yes 2 🔀 No		rio i liouri, otoly		k, White,		
-00 nours atura cal E	ete	15. Decedent's Ed	Year or Dates.	16a Decede	ent's Usual Occup	eation			Whit		
215	lg III	(Specify only highest grade Elementary/Seconday (0-12)	de completed) College (1-4 or 5+)	(Give kii	nd of work done of NOT use retired)		orking	16b. Kind of Bu	isiness in	dustry	
withi giene generations t, the	ပြို	12	College (1-4 of 54)	Ow	ner/Oper	ator		School	_of	Dance	
ind e filed tal Hy ed oth	To Be	17. Father's Name (First, Middle, Last)					ame (First, Middle,		,		
ryla uld be 1 Men narke	-	Ashby L. Leeth					illian M.				
Paltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ratural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Ty) Eloise L. Zveare/					Rural Route Number cle, Silv				6
Te, 1 and f Hea item other		20a. Method of Disposition		Place of Disposi	tion (Name of		Date	20c. Location -			
Page net o		1 Burial 2 K Cremation 3 4 Donation 5 Quere (Specify	ricijovaji ilolili otate		tory or other place tan Crem		ec. 29, 2010	Alexand			
ati rmit. spartn sports sports spinju		21. Signature Funeral Vice License	/ /	22.	Name and Addres	ss of Facility					
# 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		9 last (- t					ns Funera		Inc. prin	g, MD 2	0901
		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on	ications that caused the deat e cause on each line.	h. Do not enter	the mode of dyin	g, such as cardia	ac or respiratory arr	est,		Approximate Interval Betwe	
→Ph sician/ Medica		Immediate Cause (Final disease or condition resulting in death)	Congestive I		ailure				_1	Onset and Dea	ath
Examine		resulting in death)	Due to (or as a consequ	,							
	ĕ	Sequentially list conditions,	Coronary Art		sease				- 17	10 yrs.	
ted d unsit	Examiner	Sequentially list conditions, if any least of the first cause. Enter Underlying Cause (Disease or linjury	Hypertension	,						10 yrs.	
exect an and rial-tra	Ë	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):							
Box 68760 death certificate be executed re attending physician and ed for use as the burial-transit	dical		d								
ox 687 eath certifica attending pl	/Me	IF FEMALE:	On Maria automa of annual								$\neg \neg$
P.O. Box 687 that the death certific ned by the attending is detached for use as	by Physician/Me	in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3 🔲 I	Ectopic pregnanc Other (specify)	у		23d. Dat Mor	e of delive	ery Day Yea	ar I
	Jysic	1 ☐ Yes 2 🛂 No 9 ☐ Unknown	9 Unknown	Jean 5 🗆 (Other (specify)				1617	Day 100	
Records, P.O. By The law requires that the de ate has been signed by the page 2 should be detached	y P	Part II. Other significant conditions con	ntributing to death but not res	ulting in the und	derlying cause giv	en in Part I.	23e. Did to	bacco use contri	bute to th	e cause of deat	th?
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cian:	Be (25. Was case referred to medical examiner?			26. Pla	ace of Death (Che		E LL HOJ			
Physic Physic this c	은	T Tes 2 LETNO	ospital:			4 L Nursing	Home 5 Resid	ence 6 🗆 Othe	r (Specify,)	
ding F h. After funer	Certificate;	27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	?	28d. Describe h	ow injury occurre	d		
SIOI Attend deatl ctor: y the	ļij.	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	me farm stree		Yes 2 No	28f Location (S	treet and Numbe	r or Pural	Pauta Number	
Division of Vital Records, lal or Attending Physician: The law requires is after death. In Director After this certificate has been signed in by the funeral director, page 2 should by		4 - Homicide determined	building, etc. (Specify,		t, rabioly, office		City or Town		r or nurai	noute Number,	
Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical	29a. Certifier 1XXCertifying Physi	cian: To the best of my knowl	edge, death oc	cured at the time,	, date and place,	and due to the cau	se(s) and manne	r as state	d.	
the H hin 24 the Fu	Mec	only and 3 _ Certifying Nurse	er: On the basis of examination Fractionar to the best of my	and/or investig	eth unmurried at the	three date and p	at the time, date ar	nd place, and due	to the cau	use(s) and manne	r stated.
S d with		29b. Signature and title of certifier United States	2 4 2		29c. License	_		29d. Date signed			
7						1918		DECEMBE	R 2	9, 2010	
		30. Name and address of person who co Warren Ferris, N				vd., Sil	lver Spri	ng,MD 2	0906		
Sta	te -	31. Date filed (Month, Day, Year)	32 Registrar's Signat		1000						
Registr	ar	JAN 0 3 2011	Chave B	par	ر المراجع						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ December 25, 2010 Haskell Walter Todd 12:45A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Burtonsville Montgomery Sanctuary at Holy Cross If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
July 22, 1936 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. Months Washington, DC 220-32-5943 74 Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Prince George's Beltsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 must be r Funeral 13010 Elkridge Street 20705 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. ģ ō 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White Specify: "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Ith and Mental Hygiene. 27 is marked other than r traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Power Plant Operator PEPCO Be 18. Mother's Name (First, Middle, Maiden Surname)
Catherine Plumber Father's Name (First, Middle, Last) ဂ္ Haskell W. Todd, Sr. permit. Page 1 and 2 should be Debartment of Health and Meni Indoortant: If item 27 is marke any injury or other traumatic to 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13010 Elkridge Street Beltsville, Maryland 20705 Geraldine D. Todd -wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 12/28/2010 Alexandria, Virginia 4 Donation 5 Other (Specify) Signature of Juneral Service Licens Bonarich WirsBorgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Lung Cancer with Metastasis Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) rot 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

ASNEEM
31. Date filed (Month, Day, Year)

JAN 03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 29 James Carlton 2010 Willey 8:00 a^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5143 Airport Road Salisbury Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 D F $M_{ay}^{(Month, Day, Year)}$ 1943 216-80-2698 Maryland Director 67 Usual Residence of Decedent or items 23a or 28a-f show 10a, State 10b. County other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Wicomico Salisbury 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5143 Airport Road 21801 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force 1 Never Married 2 Married Black, White, etc. Completed by ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white "natural", If Yes, Give 3 🗌 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) never worked none marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Emmitt Rastall Willey Marjorie Hilda Layton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B. Ellen Collins sister 622 Red Bird Lane, Harrington, DE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important; If ite any injury or ot cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park 1/3/11 Cambridge, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 11 long 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final pneumonia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending physics as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 2 No g Unknown 9 Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page performed? Yes 2 X No after death.

Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 X No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

completed filled in by

Registrar

29a. Certifier (Check

only o 29b. Signature an

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

asser

DHMH 17 Rev 7/2009

Quuevia

🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

0060950

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

Physician	
/Medical	
Examiner	

1 - For State Registrar

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantiant must be untilled anone.

Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, State Registrar DHMH 17 Rev 1/2001

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5. Social Security N		6. Sex	7. Age (In yrs. last b		If Under 1 Year	If Under		8. Date of Birt (Month, Day	h ,	9. Birti	hplace (State or Fore
196-12-9	9346	1 □ M 2 🙀 F	84	Yrs.	Months Days	Hours	Min.		y, Year) 1926		^{uintry)} ` NNSYLVANI
Usual Residence of	0.0							27.17	1,20		TISTEVATI
10a. State	10b. County		10c. City, Tov	wn or Loca	ition						10d. Inside City Lim
MARYLAND	DOF	RCHESTER			C	CAMBR	IDGE				1 ¥ Yes 2 □
0e. Street and Nun	mber				10f. Zip Code				10g. Citize	en of What Co	untry?
31	8 GLENB	URN AVE.,	APT. 306			2161	3			US	SA
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7. Father's Name (,	,				io. Wothe		(First, Middle,		,	
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9a. Informant's Na				b. Mailing	Address (Street						, ,
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0a. Method of Disp 1 ☑ Burial 2 □		3 ☐ Removal from	State 20b. Place cemet	ot Disposit ery, crema	ion (Name of tory or other plac	ce)	Di	ate	20c. Loc	ation - City or I	rown, State
4 Donation	5 ☐ Other (Spe	ecify)		-	ETER ANS CEME			/2010		HURLO	OCK, MD
21. Signature of Fu	neral Service	nsee		22.1	Name and Addre	ss of Facilit	у				
1	de	1-		CUR	RAN-BROMV	VELL FU	VERAL I	HOME, P.A.,	308 HIC	GH ST., CAM	1BRIDGE, MD 21
23a. Part : Enter th shock, or hear	he disease, or c rt failure. List o	inly one cause on a	caused the death. Do		=	_			rest,		Approximate Interval Between
Immediate Cause (I	(Final	Art	erioscierol	15 C	notional	(id en	11:1	10 ell			Onset and Death
resulting in death)		a					Cen				
	- 1	Due to	(or as a consequence	e of):	^ ^	/.	and a				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene U | U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 435 Roger Alden Winters Medical December 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Poninsula Regional Medical Center Wicomic 8 Date of Birth (Month, Day, Year) Jan 18 1 If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 D F Days Hours Min. Director Country) 220-32-4490 937 Maryland Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Somerset <u>Princess Anne</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 27070 Oriole Road 21853 U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Foodservice <u>M</u>eat Cutter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Alvie Winters Holice Friend 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita D. Winters, <u> 27070 Oriole Road, </u> Princess Anne, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State St. Peters Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 01/05/11 Oriole, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home MO0295 11673 Somerset Avenue, Princess Anne, Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician/ oulmonary 10 long-thic disease or condition Medical resulting in death) Examiner oulmona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Year Yes 2 No 9 Unknown been signed by t should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 🗹 No Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗌 No after death Accident Investigation Sulcide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f, Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) e Funeral E Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 within 2 Certifying Norse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

ANTHONY J. FREY

31. Date filed (Month, Day, Year)

mD

29 2010

100

32. Redistrar's Signature

SALISBURY Md.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Rea. No. 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year Weatherhe 150 AM Janet Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death alish Vicomic foninsula Regional Medical Conter 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Funeral 1 □ M 2 🌠 F Days Director 213-44-0851 February, 2, 1945 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10h County 10c. City, Town or Location Director Cristield Somerset 1 Yes 2 No Maryland 10e. Street and Number 10g. Citizen of What Country? Funeral 301 U.S.A luler 21817 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 1 ☐ Yes 2 No Specify: and Mental Hygiene.
is marked other than "natural", Specify: Black 3 Widowed 4 Divorced Year or Dates. traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bryn Mawr Hospital 12 tharade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Cott man Mc Cready Harland Naomi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Crisfield 5+ Coxen-, md, 21817 Raymond injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Marion Station, md. 12-31-10 4 Donation 5 Other (Specify) Ebenezar U.M.C. cometery! Ammony E. Ward f. H. Ave, Princess Anne, Md. 21853 21. Signature of Funeral Service Licenses 30639 Hampden 23a. Part 1. Enter the disease, or complications thit caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): burial-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnam 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 mopt Dav Pregnant at time of death 2 No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icubates 1 Yes 2 No 3 Probably 4 Winnown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 pertension Jas 2 N 2 No Yes 1 Yes 25. Was case referred to medical examine?

1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) funeral director, Hospital 2 🗌 No Other: م| 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: At Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, ceath occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 only one) 29b. Signa 1006327 0 f person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

Records, P.O.

Division of Vital

100 Power

Salisbury

21805

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		1	For State Registrar	State of M	larylan	•	artment of H tificate of L		and M	lental Hy	giene Reg. N	ODIO	1. 2	876
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Exan	ninei		Union Hospital		untv			r Location kton	of Death		4	c. County of Deat Cecil	h	
Funer		5				ast birthday)	If Under 1 Year Months Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Bir (Month, Da		9. Birt	hplace (St	ate or Foreign
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5-00 hours hatur dical E	150		15. Decedent'	s Education		16a. Deced	ent's Usual Occup	ation			16b.	Kind of Business	ndustry	
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Maryla 2 should be th and Men 27 is marke traumatic			19a. Informant's Name/Relationship			1	g Address (Street						,	
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Page nent c ant: If			1 A Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp	Removal from State	Meri	emetery crem th East nodist	united United Cemetery	e) J	Janua 201	iry 4,		th East,		
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or othe	ouce.		21. Signature of Fundal Sovice U.	2000		22.	Name and Addres	ss of Facil	ity Cro u	ich Fun	era:	1 Home		
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Prysicia) Medic	_		shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause / n each line a. ue to (or as	Res	gns ch	itary	Ja	1/2	<u></u>			Interval	Between and Death
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OT VITAI HECORGS, Ig Physician: The law requires ter this certificate has been signeral director, page 2 should b	Completed	٠								24a. Was auto perfo	psy ormed?	death?	ompletion	of cause of
/Ital KeC sician: The la s certificate ha lirector, page 2	Be C		25. Was case referred to medical examiner?				26. Pl	ace of Dea	ath <i>(Check</i>	1 ☐ Yes only one)	2 LgLK	¶o 1 ∐ Yes	2 🗆 No	
f VIT Physic this ce	P	2	1 Yes 2 No			ER/Outpatien		4 ∐ N				6 ☐ Other (Speci	fy)	
onding I diff. After funer	S		1 Natural 5 Pending 2 Accident Investiga	28a. Date of inju (Month, Da		28b. Time of injury	28c. Injury work M 1 🗀	yat :? Yes 2.⊑	- 1	8d. Describe h	now inju	ry occurred		
DIVISION Of VITAI To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:		3 Suicide 6 Could no 4 Homicide determine	t be			et, factory, office		2	8f. Location (S		nd Number or Rur	al Route N	umber,
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vithi To th			29b. Signature and title of certifier	1.1C P.	1-311		29c. License	number	2 2 (57	29d. Da	ate signed (Month	Day, Year)
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State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 26 Physician/ Essie Gray Walker December 2010 9:35 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Month, Day, Year) Feb. 2 1913 Months Days Hours Min. 97 **Director** 241 40 3568 Usual Residence of Decedent Show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits MD Prince George's Temple Hills 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 2058 N. Anvil Lane 20748 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 XWidowed 4 Divorced SpecifyBlack Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Families Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o Garfield Carpenter permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Bessie unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Harris/ Daughter 2058 N.Anvil Lane Temple Hills, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place)
CarolanaBiblical 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Raleigh, NC 01/04/11 4 ☐ Donation 5 ☐ Other (§pecify) 22. Name and Address of Facility William Toney's Funeral Home 21. Sign of Funeral Service P.O. Box 430 Spring Hope, NC 27882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner CORDNANI Ecquentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day 5 Other (specify) Month Year Pregnant at time of death the s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 1 🗌 Yes Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide Pending 1 ☐ Yes 2 ☐ No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Decrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on 29b. Signatu d title of certifi 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink Finsure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ De~cember_pay30 2610 Mary Ann Hebb Wilkins 17:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Mary's Leonardtown Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Mar • 22 If Under 1 Year If Under 24 Hrs. Funeral 9. Birthplace (State or Foreign Days Hours 71 Country Director 214 58 0923 Usual Residence of Decedent show 10a. State 10b. County notified at with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits 28a-f MD St. Mary's Lexington Park 1 ☑ Yes 2 ☐ No 10e Street and Number 0 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 46593 Valley Court Unit 9016 20653 USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. "natural", or þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 No Specify. Specify:Black 3 Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) health and Mental Hygene.

n 27 is marked other than "n traumatic event" Elementary/Seconday (0-12) College (1-4 or 5+) 10th Housewife Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ans. James Ignatius Hebb, Sr. Mary Florine Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene F.Wilkins/Daughter 44755 Jeeter Way California,MD 20619 20b. Place of Disposition (Name of cemetery, crematory or other placem 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St.FrancisXavier Jan.7,2011 Leonardtown,MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityBriscoe-Tonic Funeral Home 2294 Old Washington Rd.Waldorf,MD 20601 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ardiac disease or condition resulting in death) MAIL WAS Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) resulting in death) Last the attending physician Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Year Day 1 Yes 2 L 9 Unknown should be detached P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No Vital within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🗶 No ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Division of Certificate: 27. Manner of Death 28h. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D60177 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 524 BOX 31. Date filed (Month, Day, Year, 32. Registrar's Signature State JAN 0 4 resend

Registrar

1. Decedent's Name (First, Middle, Last) Physician/ Charles R. Williams Medical 4a. Facility Name (if not institution, give street and number) Examiner Shady Grove Adventist Hospital 5. Social Security Number 6 Sex **Funeral** 1 🖾 M 2 🗆 F 214-34-9910 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 72 hours after death with the Maryland event, the Medical Examiner must be notified at Director Maryland | Montgomery 10e. Street and Number items 23a Funeral 5940 Lemay Road 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☒ Yes 2 ☐ No 1960-1 ☐ Never Married 2 🙀 Married than "natural", or þ X Yes Maryland 21215-0036 If Yes, Give 3 Widowed 4 Divorced Completed 1963 Year or Dates. 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cermit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic sweet the part in the contract of the contract in Be 17. Father's Name (First, Middle, Last) မှု George Franklin Williams 19a. Informant's Name/Relationship (Type, Print) Dolores E. Williams (Wife) Baltimore, Noterial Page 1 and 2 20a. Method of Disposition 1 A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service M00689 Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Pregnant at time of death g Unknown 9 Unknown detached P.O. þ signed | Completed by Records, has To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page Division of Vital 25. Was case referred to medical Be examiner? Hospital: 1 Yes 2 No ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be determined Medical 29a. Certifier

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death December 28, 2010 2:40 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery 8. Date of Birth
(Month, Day, Year, 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Min. Days Hours Country) Virginia 10c. City, Town or Location 10d. Inside City Limits Rockville 1 X Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 20851 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No Specify: Specify: White 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Sales 16b Kind of Business Industry Auto Supply Company 18. Mother's Name (First, Middle, Maiden Surname) Mary Morningstar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5940 Lemay Road, Rockville, Maryland 20851 January 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

Mt. Zion
Cemetery Bethesda, Maryland 2011 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock or heart failure. List only one cause on each line. Approximate Onset and Death neumonici. 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) Dav Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown estive HearT Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 No 1 Tyes 26. Place of Death (Check only one) Other: 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Note Cular Dr. Rockville, MD 80850 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

			For State	State o	f Marylan				Mental Hygi	ene g. No.2 0 1 0	1.2221
			Registrar 1. Decedent's Name (First, Middle,	Lant	-	Cer	tificate of I	Jeatn	T		172000
	Physicia Medic		Fred	Ernest	Wel:	ls			2. Date of Death Month December	Day Year	3. Time of Death 5:30 P.M
	Examin		4a. Facility Name (if not institution,				4b. City, Town, o	r Location of Deat		4c. County of Deat	
			Potomac Valley	Nursing (Center		Rocky	/ille		Montgome	ery
	Funeral			6. Sex 1 2 M 2 ☐ F	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day,) Sept. 13	(ear) 9. Birt	hplace (State or Foreign untry) ansas
	Director		509-18-7938 Usual Residence of Decedent		9.) 113.			Sept. 13	, 1915 K	ansas
and	shov	Ď	10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
Viany	8a-f	rect	Maryland Mont	gomery	Ga	ithers	burg				1 🖾 Yes 2 □ No
the	s or 2 se no	Ö	10e. Street and Number	<u></u>	<u> </u>		10f. Zip Code		10	g. Citizen of What Co	untry?
death with the Maryland	s 23a nust l	Funeral Director	415 Russell Ave	enue, #813	3		20877	7		United S	States
death	item ner n		11. Marital Status	Armed For	dent Ever in U.S		Vas Decedent of H	lispanic Origin? (Span, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Amer	
after So	l", or kamii	l by	1 ☐ Never Married 2 🔀 Marri 3 ☐ Widowed 4 ☐ Divorced	ied 1 X Yes	2 □ No		☐ Yes 2 🔀 No			Black, White Specify:	
within 72 hours after	atura cal E	etec		Year or Da t's Education	tes. WW I		ent's Usual Occur	action		WI	nite
113	ental Hygiene. rked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	Completed by	(Specify only highes	st grade completed)	4 5 - 1	(Give I		during most of wor	rking	6b. Kind of Business	Industry
within	giene er tha the		Elementary/Seconday (0-12)	College (1-	4 or 5+)		eorologis		N	ational We	ather Servic
E	d oth	Be	17. Father's Name (First, Middle, La	ast)				18. Mother's Nar	ne (First, Middle, Ma	iden Surname)	
Maryland 2 should be filed	Ment arke	ပ	Atho1	Wells					Effie	Burrows	
Mar shou	is in	- 4	19a. Informant's Name/Relationsh			11				ity or Town, State, Zip	
e, s and 2	Health		Margaret C. Well 20a. Method of Disposition	<u>ls/Spouse</u>				zenue, #8		ersburg, N	
10 1	intoff interference		1 🗓 Burial 2 🗆 Cremation		State C	emetery, cren	sition (Name of natory or other plac			Oc. Location - City or	
Saltimore, permit. Page 1 and	urtmer urtant njury		4 Donation 5 Other (S)		Par		Mem. Par			ockville,	Maryland
Derm Derm	Department of Health and Mental F Important: If item 27 is marked of any injury or other traumatic ever		21. Signature of Funeral Service Li	pensey had	MOUICE				Vol Funer	al Home hersburg,	MD 20877
			23a. Part 1. Enter the disease, or	complications that c	aused the deatl						Approximate
- Ph	sician/		shock, or heart failure. List or Immediate Cause (Final			- 11					Interval Between Onset and Death Weeks
) i	Medical		disease or condition resulting in death)		iratory or as a consequ		re			-	Z weeks
E	kaminer		Sequentially list conditions,	, Aspi	ration	Pneumo	nia				2 Weeks
T.	æÐ.	ine	if any leading to immediate cause. Enter Underlying	Due to	or as a consequ	ience of					
scuted		xan	Cause (Disease or linjury that initiated events resulting in death) Last	c	or as a consequ	ience off:					
oe exe	attending physician and for use as the burial-transit	dical Examiner	resulting in deathy cast	Due to (or as a consequ	icrice oi).					
cate b	s the	edic		d							
certifica	nding use a	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo						23d. Date of deli	iverv
death o	e atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 🔲 Pregr	Birth 2 ☐ Feta nant at time of c		Ectopic pregnand Other (specify)	СУ		Month	Day Year
the C	by th tache	Physician/Me	9 Unknown	9 🗆 Unkn							
s tha	igned be de	by	Part II. Other significant condition	is contributing to de	eath but not res	ulting in the u	nderlying cause gi	ven in Part I.		cco use contribute to	
cords, aw require	een s	eted	Dysphagia						1 ∐ Yes	2 🔀 No 3 🗆 Pr	obably 4 Unknown
	hasb e2sh	Completed by	End Stage Demen	tia					24a. Was an autopsy	prior to c	opsy findings available completion of cause of
L He	icate r, pag		05. W	-					performe 1 Ves 2		2 🗆 No
siciar	certif	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:			Oth	ace of Death (Chec			
Phy P	eral d	e:	27. Manner of Death	28a. Date o	npatient 2 of injury	28b. Time of	28c. Injur		ome 5 L Residence 28d. Describe how	ce 6 Other (Speci	fy)
nding	ath. r: Afte ie fun	icat	1 ☒ Natural 5 ☐ Pending 2 ☐ AccidentInvestig	, ,	h, Day, Year)	injury	M 1 🗆	? Yes 2 ☐ No		,,	
r Atte	recto	Certificate:	3 Suicide 6 Could n 4 Homicide determin	28e. Place	of Injury - At ho		et, factory, office			et and Number or Run	al Route Number,
	urs aff ral Di lled in				-				City or Town, S		
Hosp	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transfer.	Medical	(Check 2 L Medical Ex	caminer: On the basi	s of examination	and/or invest	gation, in my opinio	on, death occurred a	at the time, date and i	(s) and manner as star place, and due to the c	ause(s) and manner stated.
o the	omple	Σ	only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practioner: T	o the lest of my	knowledge, d	eath occurred at th	e time, date and pla	ace, and due to the ca	use(s) and manner as s d. Date signed (Month)	stated.
F A	7		1 4	271	10	11)	D624			December 3	
l	,	ł	30. Name and address of person w	ho completed cause	of death (Item	23a) (Type, P	rint)				
			Dr. Sayed Elsa				cular Dr	ive Ro	ckville,	20850	
	Stat	-	31. Date filed (Month, Day, Year)	011 32/Re	gistrar's Signat	re A					
	Registra	18	AWW AS S	THE LAND	and to	C MAN					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 23, 2010 9:30 а м John Lawrence Ward Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Alfred House Rockville Montgomery Social Security Number 8. Date of Birth (Month, Day, Year) Nov. 22, 1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 9. Birthplace (State or Foreign 1₹ M 2 □ F Months Days Min Hours Country)
D.C 578-14-2789 91 Director Nov. Usual Residence of Decedent show 10a. State 10b, County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f she notified MD Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 14801 Pennfield Circle, #202 20906 IISA ıral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Yes 2 No
If Yes, Give
Year or Dates. 1942-46 1 Never Married 2 Married Maryland 21215-0036 Specify White 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Financial Specialist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ John Lawrence Ward Anna Monica Carberry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick Anthony Ward/Son 4304 Mt. Olney Lane, Olney, MD 20832 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State DEC. 30 4 ☐ Donation 5 ☐ Other (Specify) 2010 Silver_Spring, MD 21. Signature of Funeral Service License 22. Name and Address of Facilit Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Metastatic Lung Cancer 3 mos Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month 9 Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Alzheimer's Disease Completed 1 Yes 2 No 3 Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy nin 24 hours after death.

the Funeral Director; After this certificate I nipeted filled in by the funeral director, pag Yes 2 X XV 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? Hospital: Assisted Living 2 🔀 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🖾 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🖄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D24543 December 29, 2010 10+1 Iddress of person who completed cause of death (Item 23a) (Type, Print)

Rossi, MD 3305 N. Leisure World Blvd., Silver Spring, MD 20906

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

			For State Registrar		State of Ma	aryland		artment of H rtificate of I			iene] (ag. No.	ا ا	+ Z 8 8 Z
. 5	Physici	an.	1. Decedent's Name (F		•					2. Date of Deat Month	h Day	Year	3. Time of Death
	/Medic		Ruth	Sander		allacl	ζ			Dec. 28	, 2010		10:00 A M
	Examin	er	4a. Facility Name (If no						Location of Death		4c. County		
140		-	Potomac Va 5. Social Security Number			e (In yrs. /as	t birthdav)	Rockv If Under 1 Year	IIIe If Under 24 Hrs.	8. Date of Birth	Mont		
	Funeral Director	g.	147-26-1778	3	1□M 2X F	77	Yrs.	Months Days	Hours Min.	Sept. 24	Year)	New	place (State or Foreign ntry) Jersey
	yland how		Usual Residence of De 10a. State 10	b. County		10c. City, 7	Town or Lo	ocation					10d. Inside City Limits
	Ba-fs	Director		Montgom	ery	Ro	ckvi	11e					1XTYes 2 □ No
	with the		10e. Street and Number 1235 Poto	-	llow Dood			10f. Zip Code	-0	1	0g. Citizen of V		ntry?
	eath ns 23.	Funeral	11. Marital Status	mac va.	12. Was Decedent	Ever in IIS	13	208.		porify Vec or No-	USA 14 Bacı		can Indian,
2-0030	72 hours after death with the Maryland "natural", or items 23a or 28a-f show Alical Examiliar must be notified at	þ	1 ☐ Never Married 3 ☑ Widowed 4 ☐		Armed Forces? 1 ☐ Yes 2 💥 If Yes, Give Year or Dates:		1	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2∑ No	Specify:	Rican, etc.)		k, White,	etc.
- C	"natural",	Completed	(Spacify	. Decedent's E	ducation ade completed)		16a. Dece	dent's Usual Occup	ation	rina	16b. Kind of Bu	isiness/In	idustry
N	c - 3	npie	Elementary/Seconda		College (1-4or 5			kind of work done o DO NOT use retired	t)				
7	filed w Hygier thar ti		17. Father's Name (First	et Middle Las	4		Admin	istrator	18. Mother's Nam				sociation
	d be t	o Be			nderson				Ethe1	Charlto		θ)	
	2 should be and Menta is marked raumatic ev	ို	19a. Informant's Name				19b. Mailir	ng Address (Street				State, Zij	o Code)
	and 2 salth a n 27 is		Matthew D.	Wallac	k/Son		7 Bir	chwood Ct	. Prince	ton June	tion, N	J 08	3550
9	of He		20a. Method of Disposi		Removal from State	20b. Plac	e of Dispo	sition (Name of matory or other place	ne) Decem	Date iber 29.	20c. Location -	City or To	own, State
аппо	Pages ment of tant: If it lury or o		4 ☐ Donation 5 [Other (Speci	fy)			natory or other place tan ry		10			Virginia
g	permit. Page Depertment of Important: If any injury or ance.		21. Signature of Funer	al Sen ce Lice	M013	315		2. Name and Address 22 Wiscor					0.0007
	40144	-	23a. Part1, Enter the c	lisease or con	polications that caused	the death						.OII , L	Approximate
	Neuroinian		shock, or heart fa Immediate Cause (Fin	ilure. List only	one cause on each li	ne. ()			_	or roophatory arre	331,		Interval Between Onset and Death
*	Physician /Medical		disease or condition resulting in death)	-	a Due to (or as	a consequer	ce of):	morni entia	مر				2 weeks
I	Examiner				b	T	-em	ent la					48011
	B = 10	ner	Sequentially list condit if any, leading to imme cause. Enter Underlyin Cause (Disease or inju-	diate	Due to (or as	a consequer	ice of):			· <u> </u>			4
	and trans	Examin	Cause (Disease or inju that initiated events resulting in death) Last		c								
Ö,	ician burial	al E			Due to (or as	a consequer	ice or):						
00/00	g physician and as the burial-transit	edical			_ d.								
×	nding use a	n/Me	IF FEMALE: 23b. Was decedent pre	agnant	23c. If yes, outcome						23d. Dat	e of deliv	erv
j .	w requires that the death certii been signed by the attending should be detached for use a	Physician/M	in the past 12 mor 1 Tes 2 No. 9 Unknown	nths?	1 □Live birth 4□Pregnant at 9□ Unknown			Ectopic pregnancy Other (specify)			Moi		Day Year
٦, ٦	s that pred b	by PI	Part II. Other significal	0			ng in the u	nderlying cause give	en in Part 1.	23e. Did tob	acco use conti	ribute to t	he cause of death?
ecords,	en sig			ra	ricing	3001		0184	ease	1 □ Ye	s 2 No	3 Proi	bably 4 Unknown
ວ ວ	as be	Completed								24a. Was a		Vere auto	opsy findings available ompletion of cause of
ב =	cate h	Con								perform	ped/2	death?	2 No
VII	certifi ector	Be	25. Was case referred examiner?	to medical	Hospital:			Othi	26. Place of Deat			-	
5 8	Phys rthis ral dii	. To	1 Yes 2 No 27. Manner of Death		1 🗆 inpatie		Outpatier b. Time of	IL 3 DUA	4 Nursing Ho	ome 5 Reside			fy)
INISION	nding tth. :: Afte e fune	Certification:	1 ⊠Natural 5	Pending investigation	28a. Date of Inju (Month, Da)	Year)	Injury	Worl	k? Yes 2 □No		m mjary socor.		
2	Atte	ifica		Could not be		ury - At home	, farm, str	eet, factory, office		28f. Location (St. City or Town		er or Run	al Route Number,
5	ital or irs after ral Dir led in	Cert	T		Dullding, 6th					City of Town	i, Siale)		
	To the Hospita of Attanding Physician: The law requires that the within 42 hours after death: within 42 hours after death: To the Funaral Director: Alter this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical	29a. Certifier 1 (Check only one)	Certifying Pl Medical Exa	nysician: To the best miner: On the basis of and manner sta	examination	dge, death and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the cared at the time, da	ause(s) and ma ate and place, a	nner as s and due t	stated. o the cause(s)
ı		Σ	29b. Signature and title	of certifier	Q00.	42	200	29c. License	000/		9d. Date signed	1	
•			30. Name da dress	of person who	completed cause of d		Т За) (Туре,	Print)	^ ^		3	01	20/0 MD 2031
		1	DRA ME	ENDH	IKAT76		101	Kescan	Ch 53LV	D Suite	= 330	KOC	kulle
	Sta Registr		31. Date filed (Month, I		32. Registr	ar's Signatur	B A	A.S.					
DUM	H 17 Bey 1/2		ON IN	43 40	Rolling	1 18.	A STATE OF THE PARTY OF THE PAR	9					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ 2010 James Keay Young December 8:20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 20115 Sweet Meadow Lane Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Date of (Month, Day, Ye 9. Birthplace (State or Foreign 043-24-9594 Year) 1931 Connecticut 1 XM 2 - F **Director** 79 Dec. Usual Residence of Decedent or 28a-f show 10a. State 10b County death with the Maryland Examiner must be notified at 10c. City, Town or Location Director Maryland | Montgomery Gaithersburg 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 20115 Sweet Meadow Lane 20882 United States 12. Was Decedent Ever in U.S. Armed Forces? 1957

1 Yes 2 X No If Yes, Give 1959 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 within 72 hours after 1959 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Space Communications
Engineer 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) . Page 1 and 2 should be filed within 72 treet of Health and Mental Hygiene. tant: If item 27 is marked other than 'iury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Aerospace Corporation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Thomas Young Kathleen Horrigan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan T. Young (Spouse) 20115 Sweet Meadow Lane, Gaithersburg, MD 20882 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Date 1 Burial 2 X Cremation 3 Removal from State Metropolitan January 4 ☐ Donation 5 ☐ Other (Specify) 2011 <u>Alexandria, Virginia</u> Crematory Signature of Funeral Service Licens 22. Name and Address of Facility DeVol Funeral Home, M00689 10 E. Deer Park Drive, Gaithersburg, MD 20877 Part Denter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should be heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ METASTATIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner COMPRESSION OND Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) e burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed 'lifled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events NEUROENDOCRINE Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year 5 Other (specify) Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗷 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) to title of certifier 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 10+1 7117 Ma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Julie T. Dang, M.D.,

JAN 03 201

31. Date filed (Month, Day, Year

32. Registrar's Signature

9001 Medical Center Drive, Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:06 PM <u>Richard George Zeisloft</u> December 2010 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Kent <u>Chester River Hospital</u> Chestertown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Country) Pennsylvania 8. Date of Birth **Funeral** 1 X M 2 - F 209-30-3090 Director 70 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Marvland Queen Anne's Centreville 10e. Street and Number 10g. Citizen of What Country? Funeral 150 Taylor Rd. 21617 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates. 1957–61 3 X Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gordon Zeisloft Margaret Pealot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon J. Rubino/ Daughter 2806 Tellier Ct., Crofton, Maryland 21114 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 12/29/10 Edgewater, MD 21. Signat July e al Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home mule <u> 2973 Solomons Island Rd. Edgewater, MD</u> 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician, Medical HOUTE disease or condition resulting in death) MYOCARAIAL 1600 Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Que to for as a consider ou of: Exami been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hours after death.

uneral Director. After this certificate has af filled in by the funeral director, page 2. autopsy performed obs tructive 2 No 1 🗌 Yes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 II No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Sallitt Drive, Stevensville, MD 21666

115

32. Registrar's Signature

M.D

<u>Jamie Harms.</u>

31. Date filed (Month, Day, Year)

Physician Medica Examine Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

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	Registrar 1. Decedent's Name (First, Middle, La	ast)		lilicate of L	eaur		2. Date of Deat	leg. No	1 0	3. Time of Death
/	Sammy Joseph Aiel	*				- 1	Month Decembe	Day	Year O10	12:00 p ^M
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	23 Delta Place			Indian				Char		
	5. Social Security Number 6.	Sex 7. Age ('n yrs. last birthday)	If Under 1 Year Months Days	If Under 2		8. Date of Birth	Veneral O O A		place (State or Foreign
		1 XM 2 □ F 76	Yrs.	IVIOITIIS Days	Hours	IVIIII.	Aulgnth, 28	1934	Ca'1'	Mornia
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lector	Maryland Charl		Indian							1 X Yes 2 □ No
	10e. Street and Number	1	211012011	10f. Zip Code				10g. Citizen of	What Cour	
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Completed by	3 Widowed 4 Divorced 15. Decedent's	Year or Dates.	1959					Specify	AATIT	
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Pe Pe	17. Father's Name (First, Middle, Last))			18. Mother	's Name	(First, Middle, N	Maiden Surnam	e)	
익	Natale Aiello				Ма	ry D	ave			
	19a. Informant's Name/Relationship (ng Address (Street a						Code)
	Nettie M. Aiello 20a. Method of Disposition	Wife		elta Plac	e, In	dian				
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		20b. Place of Dispo cemetery, crer Metropol	osition (Name of matory or other place itan Fune	Dec ral S	erví	2010	20c. Location Alexano		own, State Virginia
	21. Signature of Funeral Service Licer		100668 W	Name and Addres 71111ams F 270 HaWIT	s of Facility UNETA	l Ho	me, P.A	A. Head.	Md.	20640
	23a. Part 1. Enter the fisease, or cor shock, or heart failure. List only	nplications that caused the	e death. Do not ente	er the mode of dying	, such as ca	ardiac or	respiratory arre	est,		Approximate Interval Between
	Immediate Cause (Final disease or condition	Car	ree	011	wh	P				Onset and Death
	resulting in death)	Due to (or as a c	onsequence of):	0		1				
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	that initiated events resulting in death) Last	C. Due to (or as a c	onsequence of):							
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completed by							1 □ Y	′es 2 □ No	3 🗌 Pro	bably 4 nknown
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							autops	med?	prior to co death? 1 🗌 Yes	impletion of cause of
	25. Was case referred to medical examiner?			26. Pla	ce of Death	(Check o	-	2 1406	1es	Z LINO
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Š	2 Accident Investigation	he -			Yes 2 1	_				
200	4 Homicide determined	building, etc. (City or Towr	n, State)		l Route Number,
Medical Certificate	(Check 2 <u></u> Medical Exam	ysician: To the best of my niner: On the basis of exar rse Practioner: To the be	mination and/or inves	tigation, in my opinio	n, death occ	urred at the	he time, date an	nd place, and du	e to the ca	use(s) and manner stated.
	29b. Signature and title of certifier	~		29c. License	number F35)	2	29d. Date signe	d (Month,	Day, Year)
	30. Name and address of person who	completed cause of dear	th (Item 23a) (Type, F	Print) SP	lcf	cı	M.	DZX	261	46
	31. Date filed (Month, Day, Year)	32. R/gistrar's		hares					•	
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MD 21	1 t e o 2	ဥ	1 1				ber, City or Town, Sta	te, Zip Code)
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Baltimore, permit. Pages 1 a	t of H		1 X Burial 2 Cremation 3 Removal from State crematory or c	ther place)	·		-	
Iti Pa	Department (Important: injury or ot		4 Donation 5 Other Specify: ST. STEPH 21. Signature of Funeral Service Licensee 22.					
Ba perm				ELLOWS, E	IELFENBEIN	& NEW	NAM FUNERA	L HOME, P.A.
Phy	/sician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter	the mode of dying,	HARRISON such as cardiac or r	respiratory arres	st, shock, or heart	21601 Approximate Interval
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	2 4 4		29a. Certifier 1 Certifying Physician: To the heat of my knowledge death accur	rred at the time, da	ate and place, and du	ue to the cause((s) and manner as stat	ted.
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate	within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investiga	29c. License	e number		29d. Date signed (Mo	
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	within 24 To the Fu completely		2 Medical Examiner: On the basis of examination and/or investiga and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a)	29c. License	e number M.E.	- 1:	29d. Date signed (Mo	nth, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 9:22 AM **Physician** Adkins Anna Belle **a**4 December 2016 /Medical Princess Hours

Ader 1 Year | If Under 24 Hrs.

Pays | Hours | Min. 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manokin Manov 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 🛛 F Months 83 218-20-8951 Director 08/24/1927 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State ns 23a or 28a-f show 1 □Yes 2 XNo Director Wicomico Maryland Parsonsburg 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number with t 32567 Morris Leonard Road 21849 USA Funeral death 7 is marked other than "natural", or items traumatic event, the Medical Examinar ma 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. iled within 72 hours after 1 Tes 2 X If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Service rural mail carrier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beatrice Maude Jackson George Thomas Hutchison ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6220 Collins Rd., Parsonsburg, MD 21849 19a. Informant's Name/Relationship (Type. Print)
Patricia Welch/daughter permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tra once. Health am 27 is 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Jerusalem Cemetery 12/29/2010 Parsonsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Licens ²²Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCUD Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Anna belle the attending physician and thed for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) detached 9 Unknown sate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 2 No 3 Probably 4 Onknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform After this certificate 2 No 1 ☐ Yes Division of Vital or Attending Physician: Be (25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 1 Natural Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 Tes after death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide thin 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 47094 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEISBURY MD 21804 NATE SAN 5 west S. DIVISIUN 1415 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Edna Adams Elizabeth 06 2010 12 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Vicomico Regional Medical Center Poninsula 2011Sbur Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏲 F Months Days Hours Min. 10/28/1926 Maryland 84 **Director** 218-16-6766 Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic even, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 🗆 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 Funeral 2301 Pineway 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ould be filed within 72 hours after of Mental Hygiene. marked other than "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🏞 No Specify. If Yes, Give Year or Dates white Specify: Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) delivery person newspaper Be .. Page 1 and 2 should be filed treent of Health and Mental Hitant: If item 27 is marked ot 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jerdie Brown Louis Brittingham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312 Gunbys Mill Dr., Salisbury, MD 21804 Linda Griffith/daughter 20b. Place of Disposition (Name of Specialty) have properly to the property of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 12/9/2010 4 Donation 5 Other (Specify) Gardens Hebron, MD 21. Signature of Funeral Service Livin 角がTRWAYでは保護機制 Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Mell st 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Pulmonar Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) emss Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or iii july that initiated events resulting in death) Last Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Hospital or Attending Physician: The law requires Records, Completed 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☑ No 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) injury 5 Pending n 24 hours after death.

le Funeral Director: After pleted filled in by the fun 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medica 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of cer 29c. License number 12/06/10 D 41721

State Registrar E. SHORE DR

SALISBURY

mp

21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IMD

PArus

YOO

32. egistrar's Signature

Please Type or Print in Black Indelible Ink Finsure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 1^{Month} 27-1^{Da} Butler Charles Sr. 8:30p M Edward Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 4761 Bryantown Rd Waldorf Charles 5. Social Security Number 6. Sex 1 **本**M 2 □ F If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min (Month, Day, Year) 2-08-1940 Country) Director 213-40-5153 70 Maryland Usual Residence of Decedent 28a-f show filed within 72 hours after death with the Maryland al Hygiene. 10b. County 10a. State 10c. City. Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1X Yes 2 ☐ No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4761 Bryantown 20601 Rd USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: Black Yes, Give 1 Yes 2 XNo Specify Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Skilled Labor Metro Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Page 1 and 2 should be Alfred Butler Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau <u>Bertha</u>Butler-Wife Bryantown Rd, Waldorf Maryland 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Mem. 1 - 3 - 11Waldorf, Maryland 21. Signature/of Funeral Service Licensee 22. Name and Address of Facility Wa Adams Funeral Home Pa, Aquasco MD 20608 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Universitying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 🗌 No 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 1 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completed filled in by the funeral 27. Mannet of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State, 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signa and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 the completed cause of death (Item 23a) (Type, Print) 30. Name and address of person MBS 13605 Baden Westwood Road, Brandywine, MD 20613 Dr Samuel Croff Jr.

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day,

32.

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Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0904 Margurette Melyin Bartz Occember Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospita Eastor Talkot @ Easton 5. Social Security Number If Under 1 Year | If Under 24 Hrs 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 💢 F Hours Sept 28 1934 Maryland 215-32-4991 76 Director Usual Residence of Decedent iral", or Items 23a or 28a-f show Examiner must be notified at 10h County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No Maryland Caroline Henderson 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 26105 Bee Tree Road 21640 U.S.A. death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 A No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) marked other than College (1-4 or 5+) seamstress manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred Melvin Roxannie Hutson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Norman F. Bartz, Jr. son 17489 Melville Road; Henderson, MD 21640 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery Jan 3, 2011-Greensboro, Maryland 22. Name and Address of Facility PO Box 160; Greensboro, MD 21639 Funeral Service Licenses Fleegle and Helfenbein Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acr ر جو disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the bunal-transit Exam or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No detached 9 I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Uniknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed Yes 2 2 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 ည 1 Depatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Hospital of 24 hours at Euneral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 1)005 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DeShields, 219 S Dennis M. MD; Washington Street, Easton, MD 21602 31. Date filed (Month, Day, Ye 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

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linton Raymond B	rown	State of Marylan	id / Department o	of Health and Mental H	ygiene		~ ~ ~ ~			
	1- For State Registrar		Certificate of	of Death	Reg. N	40. 20 TU	289			
Physician/ ledical Examine	1. Decedent's Name (First, N	Raymond	Brown		2. Date of Death Month Da September 5		3. Time of Death 1730 hrs			
	4a. Facility Name (if not insti	ution, give street and numb	per)	4b. City, Town, or Location of Death	1	4c. County of Death				

		1- For State Registrar		Certificate of Death								
Physicia ledical Examir	ın/	1. Decedent's Name (First, Middle Last) Clinton Ray						2. Date of Death Month Day September 5, 2010 3. Time of Dec 1730 hrs				
4		4a. Facility Name (if not institution, give st 1120 Ponds Wood Road	4	b. City, Town, Huntingto		Death		4c. County of [Calvert				
Funeral Director		5. Social Security Number 6. Sex 093-58-8838 1 🗆 M	7. Age (In yrs. last b	oirthday) Yrs.	If Under 1 Y Months D		24Hrs. Min.	1	(MM/DD/YYYY) 9 /1963	9. Birthplace (State or foreign Country) MD		
w any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov			2 1-				10d. Inside City Limits		
death with the Maryland ritems 23a or 28a-f show nust be notified at once uneral Director		MD Calvert		Chesapeake Beach					10g. Citizen of What Country			
		4504 Dalrymple 11. Marital Status 11	2. Was Decedent Ever in U.S.									
ifter death 1 1", or item	by Funeral		Armed Forces? Yes 2 No Yes, Give Yeal 981-200				Puerto F	Rican, etc.)	Black			
36 iin 72 hours a i. ihan "natura dicel Exami	Completed b	15. Decedent's Education (Specify only the Elementary/Secondary (0-12)	College (1-4 or 5+)	nt's Usual Occupation (Give kind of work done nost of working life. DO NOT use retired) Instructor				16b. Kind of Busin Public				
AD 21214 2 should be fil h and Mental F 27 is marked imatic event, 1		17. Father's Name (First, Middle, Last) Francis Lando				,	lame (First, Middle, Maiden Surname) Pres Ray					
		19a Informant's Name/Relationship (Type Jacquelyn Brown/	wife	4504	Dalry	mple	Rd.	Ches.		, MD 20732		
Baltimore, Remit. Pages I and Department of Healt Important: If item		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State Erne	natory or oth Stin	eJones	Cem.	12/	31/10	Ches. I	Bch.MD		
		21. Signature of Funeral Service Linesee Maskey a Sew	elf		ame and Addre					Home, PA Fred., MD206		
Physician Wedical xaminer	i i			not enter th	ne mode of dylr	ig, such as cai	rdiac or	respiratory arres	st, snock, or neart	Approximate Interva Between Onset and Death		
	Examiner	cause. Enter Underlying Cause	b. Due to (or as a consequence of): c. Due to (or as a consequence of):									
execultian and ial - tra	Medical E	d. d. A	MENDED									
Box 68760, e death certificate be of the attending physician defor use as the burnered for use as the	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand 1 Live birth 4 Pregnant at time of death 9 Unknown	Live birth 2 Fetal death 3 Ectopic pregnan					23d. Date of delivery Month D			
ires that the de signed by the detached f	by Phy	Part II. Other significant conditions co		ting in the u	nderlying caus	e given in Parl	t I.		acco use contribu	te to the cause of death? Probably 4 Unknown		
cords law requ	24a. Was an autopsy performed:									24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No		
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Division pital or Attendi ours after death. teral Director: /	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home (Specify) Local Street	e, farm, stree	arm, street, factory, office building, etc. 28f. L				off. Location (Street and Number or Rural Route Number, City or Town, State) 20 Ponds Wood Road, Huntingtown, MD			
Divis To the Hospital or A within 24 hours after To the Funeral Director Completely filled in by	Medical C											
7. 5. iv	Me	29b. Signature and title of certifier	M. /			nse number C.M.E.			29d. Date signed December 22	(Month, Day, Year) 2, 2010		
RW 15+1	ł	30. Name and address of person who com Jack Titus MD. Deputy Ch		-	ın Street, B	altimore, M	/ID 212	201				
	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	6 /	n. W. J							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death December Day 29, 2010 Physician/ Edna M. Bennett 12:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 442 Blossom Tree Drive Annapolis Anne Arundel 5. Social Security Number If Under Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 14,1910 9. Birthplace (State or Foreign Country) New York 7. Age (In vrs. last birthday) Funeral Days 1 □ M 2 😾 F Months 100 099-24-0717 Director Usual Residence of Decedent · 28a-f show 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Annapolis Anne Arundel 1 Yes 2X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 442 Blossom Tree Drive 21409 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Andrew Grieshaber Caroline Carpenter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Ann Bennett/Daughter-in-law 837 Mago Vista Road Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Memorial Gardens January Annapolis, MD 2011 21. Signature of Funeral Service Licensee Rarranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart railure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last tobacco Due to (or as a consequence of) Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this leted filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending work? Natural 5 Pending iniury 2 🗆 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined completed filled Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Box

P.O.

Division of Vital

Veterans

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

8601

32. Registrar's Signature

0063270

Suite ZII, M, MESSULLI, MD 21105

10-10109 Irene F. Brown Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

rene E. Brown	1- For State AMEN Registrar		of Maryland				id Menta		Z L Reg. No.	HU	42833
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Irene Demarr					2. Date of					3. Time of Death 1120 hrs
	4a. Facility Name (if not institution, give street and number) 8500 Laurel Bowie Road					b. City, Town, o	City, Town, or Location of Death 4c. County of Death Prince George's				
Funeral Director	5. Social Security N		7. Ag M 2 XF 92	e (In yrs, last t	oirthday) Yrs	If Under 1 Ye Months Day	8. Date of Bi	Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Maryland country)			
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 33a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	MD Prince George's Bowie 10e, Street and Number 10f. Zip Code 10g. Citize									1 X Yes 2 No	
	8500 Laurel Bowie Rd.					10f. Zip Code	715		10g. Citizen of USA	what coul	mu y ?
r death with to or items 23s must be not Funeral	11. Marital Status 1 Never Married Married Armed Forces?				n U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					ace - Ameri /hite, etc.	can Indian, Black,
s after des tral", or i niner mu by Fu	1 Yes 2 X N 3 X Widowed 4 Divorced If Yes, Give Year or Dates:				1 Yes 2 ☑ No <i>specity:</i>					fy:	White
5-0036 ed within 72 hours of within 72 hours of with than "natur to he Medical Exam Completed t	15. Decedent's Ed Elementary/Seco	ondary (0-12)	, ,		Sa. Decedent's Usual Occupation (Give kind of work dor during most of working life. DO NOT use retired) Payroll				16b. Kind of		
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene. In 27 is marked other than numatic event, the Medica To Be Comple	17. Father's Name	(First, Middle, Last)				1011		Name (First, Middle,	Maiden Surna		N
2121 Ild be fil Mental F marked event, 1	Thomas Oliver DeMarr				19b. Mailing	Address (Stre		iam Lamarı		own. State	. Zip Code)
MD 3 show lith and li	Marlyne	B. Weakle		1600	8 Parte	11 Ct.	, Bowie	, MD 2	0716		
Ore, ges l an t of Hea : If iter ither tra	20a. Method of Dis 1 Burial 2	position Cremation 3	Removal from Sta	ate , crem	natory or oth	tion (Name of ce		Date			Town, State
Baltimore, Permit, Pages I an Department of Hei Unportant: If ite injury or other training or other tr	4 Donation 5 21. Signature of Fu	Other Specify: neral Service Licens	00	Metr		matory ame and Addres		Beall Fund		ltimore, MD Home	
	23a Part I Foter th	ne disease or combli	cations that caused	the death. Do		12 NW C			wie, MD		715 Approximate Interval
Physician ⊪Medicul Examiner										Between Onset and Death	
_XaIIIIIei	or condition resulting in death) Due to (or as a consequence of):										
iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause. Enter Underlying Cause Co.										
0, e be executed systeian and burial - transit edical Examiner		(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.									
50, tte be executed nysician and burial - transit	UNPENDED		AMENDED						Tour		
3876 rtificat ing ph: as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								/ Day Year		
D. Box 6 t the death ce by the attend ached for use	Part II. Other signi		9 Onknown			nderlying cause given in Part I. 23e. Dic			tobacco use contribute to the cause of death?		
cords, P.O. B aw requires that the d has been signed by the 2 should be detached upleted by Phy											pably 4 V Unknown
Division of Vital Records, P.O. is or Attending Physician: The law requires that the rape death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact bartification: To Be Completed by Pertification: To Be	24a. Was an autopsy performed?							osy orm <u>ed</u> ?			
fital Recision: The is certificate lirector, page	25. Was case referred to medical 25. Mass									: Scene	
n of Viding Physical h. After this stuneral dir	27 Magner of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred										
Division o spital or Attending hours after death. neral Director: Affled in by the functorities of the fu	2 Accident Investigation Investigation 3 Suicide 6 Could not be determined Homicide Homicide (Specify) 2 Accident 1 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate i completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
F 3 F 3	29b. Signature and title of certifier				29c. License number O. C. M.E.				29d. Date signed (Month, Day, Year) December 31, 2010		
	30. Name and addr	ess of person who co	empleted cause of d	eath (Item 23a	a)	1			- 5551115	,	
S W	Jack Titus N			xaminer			eet, Baltim	ore, MD 21223			
State Registrar		AN 0 4 201	1 Sz. negistia	Jognature	ha	Kel					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death I. Decedent's Name (First, Middle, Last) Month Physician/ 4:30 December Joyce P. Brown Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Mandrin Chesapeake Hospice House Harwood Anne Arundel 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Year) 1937 **Funeral** Country) July 28 Days Months 1 □ M 2 🗓 F 73 243-50-6773 North Carolina Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d Inside City Limits 10a. State Director 1 X Yes 2 No Annapolis Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 21401 2032 Fairfax Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Yes Give Specify 3 X Widowed 4 Divorced White Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher vears Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sarah Katherine Smith Joshua Cecil Pierce 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 30820 Trails End, Dagsboro, DE 19939 Mary Smith/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State Kalas Crematory 12-29-2010 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify)

Signature # The Property Sept Ce Licenses 22. Name and Address of Facility George P. Kalas Funeral Home Septe Licensee Melle 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each, line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a o ns Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death signed by the aid be detached for 1 ☐ Yes 2 ↓ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed; his certificate h 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 **(**No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ this After thi 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident work? 5 Pending n 24 hours after death. e Funeral Director: Aft bleted filled in by the fur 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination lands and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 29d. Date signed (Month, 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste. 210, Annapolis, MD 21401 Rhee, M.D. 2003 Medical Pkwy. 03 2011 31. Date filed (Mont 32. Registrar's Signatu State

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ December 30, 2010 Kaushal Kishore Bhatnagar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Silver Spring Holy Cross Hospital Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 1 🗔 M 2 🗆 F Min October 24,192 212-25-6331 89 Director Usual Residence of Decedent "natural", or Items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State filed within 72 hours after death with the Maryland al Hygiene. 10c. City, Town or Location Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16612 Harbour Town Drive 20905 India Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Š 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Officer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental Lala Shri Ram Parvati Devi .. Page 1 and 2 should tment of Health and M tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vinod Bhatnagar - SON 16612 Harbour Town Drive, Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Durial 2 X Cremation 3 Removal from State Baltimore Washington Crem 12/31/2010 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Pleck Funeral Home, INC, 7601 Sandy Spring Rd., Laurel, Maryland h Pol mo123 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Cardiopulmonary Arrest Medical resulting in death) Due to (or as a consequence of) Examiner CHF Exacerbation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 9 Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires in 24 hours after death.

the Funeral Director: After this certificate has been sign Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 Yes 2 No Yes To Be 25. Was case referred to medical of Vital completed filled in by the funeral director, 26. Place of Death (Check only one) 1 Yes 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work' Division 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

12:55 AM

India

10d. Inside City Limits

1 Yes 2 X No

Birthplace (State or Foreign Country)

Asian

of India

Approximate Interval Between

Onset and Death

Day

29d. Date signed (Month. Day. Year)

December 30, 2010

Year

Registrar

DHMH 17 Rev 7/2009

29a. Certifier (Check

only one 29b. Signature and title of contifi

Satyam

31. Date filed (Month, Day, Year)

Α.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shah MD

Holy Cross Hospital

1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Silver Spring, Maryland

29c. License number

Certifying Nurse Afractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D68096

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ 25 2010 Kathleen Brawn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 22 S. Greene St N/A Baltimore University of Many and Med Center 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Apr. 2, 1947 If Under 1 Year If Under 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Pennsylvania 1 □ M 2 🔀 F Hours 173-38-3070 **Director** 63 Apr. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10h County Director 1 ☐ Yes 2 X No MD Anne Arundel Harwood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20776 USA 1221 Sandalwood Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give 1 Never Married 2 K Married Completed by White Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Religious Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ruth Conway William Noecker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1221 Sandalwood Rd., Harwood, MD 20776 Terrence H. Brown / Spouse timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State 12/30/2010 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, MD Beall Funeral Home 21. Signature of Fun and Service Licensee 22. Name and Address of Facility 6512 NW Crain Hwy., 20715 Bowie, MD Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ₽hysician/ Amudaidosis disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Dilli to (ur as a consequence of): Exam Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown detached cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available 24a. Was an Was an autopsy performed? prior to completion of cause of death? After this certificate has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 M No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 5 Pending 1 Tes 2 No 24 hours after death. Funeral Director: A Investigation 2 Accident npleted filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [within 2 To the I only one) 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2/28/10 mo

State Registrar 22 · South C 32. Registrar's Signature B

OW

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Short mr

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Madaline C. Bernard December 2010 6:30 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 103-A Eastern Avenue Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April 9 9. Birthplace (State or Foreign Funeral 185-24-3796 1 M 250 79 Months Days Hours **Director** Pennsylvania Usual Residence of Decedent 28a-f shov 10b. County 10a. State filed within 72 hours after death with the Maryland Ħ 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified Maryland Anne Arundel Annapolis 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103-A Eastern Avenue Funeral 21403 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7? Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic event, the Meany once. Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Clare Caveny Emily Dickson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103-A Eastern Avenue Annapolis, Maryland John Bernard/husband 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔲 Burial 2 🔀 Cremation 3 🔲 Removal from State Baltimore Crematory 1/3/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ MG JU disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): Examir Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown ģ Pregnant at time of death as been signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy
performed?

Yes 2 page 1 Yes 2 No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No M Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2
To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signature ar nse numbe 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

30. Name and addre

31. Date filed (Month

3

MESIL

32. Registrar's Signature

amended item 19B/1-5-2011/wchd/map Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State of Maryla State of Maryla State		artment of F rtificate of L			Reg. No.		4289	
Physici	ian/	1. Decedent's Name (First, Middle, Last)			•	2. Date of Dea		Voor	3. Time of Death	
Med		Jessie B. Barnes				Month 12	23 Day	2010	10:45 p	
Exami	iner	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	r Location of Deat	h	4c. Count	y of Death		
<u></u>		Catered Living of Ocean Pin			Pines		Wo	rceste	er	
Funera		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yr 1 M 2 DF 100	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			9. Birthp _Count	lace (State or Foreig try)	
Directo		Usual Residence of Decedent	115.			09/05/	1910	Dela	ware	
ind show	5		City, Town or Lo	cation				11	0d. Inside City Limit	
aryla ta-f s ified	ect	MD Worcester 0	cean Pi	nec					1 X Yes 2 □ I	
or 28	ä	10e. Street and Number	CCUR II	10f. Zip Code		1	10g. Citizen of	What Coun		
vith t	era	1135 Ocean Parkway		2181	1		U.S.			
within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be	Funeral Director	11. Marital Status 12. Was Decedent Ever in	U.S. 13. V	Was Decedent of Hi		pecify Yes or No-		ce - America	an Indian.	
or it mine	2	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 ★ No		If Yes, specify Cuba	in, Mexican, Puert	o Rican, etc.)		ck, White, e		
rs aff Iral", Exa	ed	3 Widowed 4 □ Divorced If Yes, Give Year or Dates.	1	1 ☐ Yes 2 🕱 No	Specify:		Specify	y: Whi	ite	
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han 7%	۱Ē	Elementary/Seconday (0-12) College (1-4 or 5+)	life. D	O NOT use retired)	iuning most of wor	king		al-d-a		
d with	BeC		Нот	memaker				making	5	
ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	lo B	17. Father's Name (First, Middle, Last)				me (First, Middle,	Maiden Surnan	ne)		
12 should be file lith and Mental H 27 is marked of r traumatic ever	-	William Henry Brown				e Reed		33431	00001	
2 sho h and 7 is r raum		19a. Informant's Name/Relationship (Type, Print)			and Number or Rural Route Numbe					
and a		Herbert Barnes, Jr. / Son 20a. Method of Disposition		NE Spanis	h River		·			
ge 1 if it		1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State	-	natory or other plac		Date	20c. Location	•		
t. Pa rtmer rtant rjury				lle Cemet						
permit. Page ' Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	22	2. Name and Addres 202 Laws	ss of Facility Par Street,	sell Fur Bridgevi	neral Ho	omes 8 E 199	Cremator 33	
Medical Examiner bhysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer unioerrying Cause (Disease or linjury that initiated events resulting in death) Last b. Due to (or as a consequence of the condition of t						- 1		
death certific he attending ed for use as	Physician/Medical	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			ate of deliver	ry Day Year				
en signed		Part II. Other significant conditions contributing to death but not		23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknow						
cate has be page 2 sh	Completed by		autop _ perfor	24a. Was an autopsy performed? 1 Yes 2 Tho 1 Yes 2 Tho						
certifi	Be	25. Was case referred to medical examiner?		Otho	ace of Death (Che			- 1		
this ral dir	2	1 Ves No 1 Inpatient 2 27. Manner of Death 28a. Date of injury	ER/Outpatien		4 L Nursing H	lome 5 Resid				
ding After fune	ate	1 Natural 5 Pending (Month, Day, Year)		work	?	28d. Øescribe ho	ow injury occuri	red		
within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Il Certificate:	Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At building, etc. (Spec	es 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
ie io⊓	Medical	29a. Certifier (Check only one) 1	ition and/or invest	igation, in my opinio	n, death occurred a	at the time, date ar	nd place, and du	e to the caus	se(s) and manner sta	
une no nin 24 h the Fur 1pleted		29b. Signature and title of certifier		29c. License	number	2	29d. Date signe	d (Month, D	ay, Year)	
In the Flospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.			- /	1 1	10 -			-		
o une flo within 24 h To the Fur completed		DO ELL I	NB	DZ	627	8	12 -	30-	15	
		30. Name and address of person who completed cause of death (lite	tem 23a) (Type, P	Print) D2	627	8	12-	30-	16	
vithin 24 P			d Ocean	rint) City Road	627 d, Salish	bury, MD	/2 - , 21804	30-	15	

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11:07PM Angeline F. Beauchamp 12 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury Coastal Hospice at the Wicanica ake 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 12, 1929 **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Hours Country)
Delaware Director 222-16-6896 81 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Sussex Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10337 Beauchamp Lane 19940 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) seamstress garment company Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Angelo Triglia Mary Rose Calarita 19a. Informant's Name/Relationship (Type, Print) (son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Beauchamp, Jr. 10257 Beauchamp Lane Delmar, 19940 DE 20a. Method of Disposition. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Riverton Cemetery Dec. 30, 2010 Mardela Springs, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13 East Grove Street Delmar, DE 23a. Part 1. Enter th: 😼 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Cerebro vasante Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Month Year Day g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ascm 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 2 🗌 No Yes To the Funeral Director. After this certification and filed in by the funeral director, and the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director director, the funeral director direc Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12/25/10 063199

State Registrar YOGES

31. Date filed (Month, P

conchange

SHORE

BK.

SALISBULY

MD 21804

910 EASTERN

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VOHRA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State o	f Marylar		artment <i>tificate</i>			and M	lental Hy	giene Reg. N	71111)	429	900
	Physicia		1. Decedent's Name		_{ast)} rietta	Во	wen					2. Date of De Month Decembe	ath Da		5	3. Time of 5:00	
	Medic Examin											40	C. County of De	eath	3.00		
	Funeral Director		5. Social Security Nu 218-05-87	'30 6.	Sex 1 ☐ M 2 🗗 F	7. Age (In yrs. I	last birthday) Yrs.	If Under 1		If Under Hours	24 Hrs. Min.	8. Date of Bir Month, Da	th 191	9.1	Birthpla Country lary	ace (State o	r Foreign
10	and show 1 at	jo.	Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	ty, Town or Loc	ation							10	d. Inside Ci	ty Limits
	Maryl 28a-f)irec	Maryland	Wicom	ico		Frui	tland									2 🗌 No
	with the	Funeral Director	10e. Street and Num 628 E	_{nber} Cast Mai	n Street			10f. Zip 0	ode 21820	6			10g. C	itizen of What USA	Countr	y?	
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Marrie 3 Widowed 4	ied 2 🗌 Married	12. Was Dece	2 🛣 No e			nt of His y Cuban	panic Orig , Mexican		cify Yes or No- Rican, etc.)		14. Race - Ar Black, Wi		C.	
11cHa 21215-0036	rithin 72 hou iene. r than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress						of workir	rking 16b. Kind of Business Indus				stry			
Hen, Maryland 2	d be filed w Mental Hygi arked othe tric event,	மெ	17. Father's Name (F)							(First, Middle, Bostic	Ma <i>id</i> en				
, Mary	nd 2 should ealth and 18 m 27 is me ier trauma		19a. Informant's Na Elizabe	me/Relationship th Hicks	(Type, Print) s/daughte	er						Route Numbe		r Town, State, . 21826	Zip Co	de)	
Bowen Baltimore, I	Page 1 arment of He rant If iter		4 Donation	☐ Cremation 3 5 ☐ Other (Spe		State Up	cemetery, crematory or other place)				.		Salisbury, MD				
Balt	permit. Depart Import any inj	1	21. Signature of Fun	neral Service Oce	nsee Lys Cl	-5P	22 H	Name and	Address AV F	of Facility	al Ho	ome Pro	fes	sional , MD 21	Ass	sociat	ion
y F	Physician/	88 6	23a. Part 1. Enter the shock, or heart Immediate Cause (F disease or condition	t failure. List only Final	mplications that cone cause on each	aused the deat ch line.	-	r the mode o リモル			cardiac or	r respiratory ar	rest,		1	Approximatenterval Betwood	ween
	Medical Examiner		resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.														
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09	ate be executed obysician and the burial-transit	dical Examiner	resulting in death) L	ast	Due to (₁	or as a consequ	uence of):										
687	certifica nding p use as t	an/Me	IF FEMALE: 23b. Was decedent p		23c. If yes, outo	come of pregna	incy	Ectopic pre	onancy					23d. Date of o	delivery	,	
D. Bo)	the death by the att tached for	hysici	in the past 12 m 1 Yes 2 9 Unknown] No	4 ☐ Pregr 9 ☐ Unkn	nant at time of o	death 5	Other (spec	cify)					Month	D	ay Y	'ear
ds, P.	requires that the death certifica been signed by the attending bl should be detached for use as t	ted by	Part II. Other signific	cant conditions	contributing to de	eath but not res	ulting in the ur	derlying ca	use give	n in Part I.				use contribute			
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for	Completed by Physician/Me			u-u-							24a. Was autop perfo 1 Yes	sy rmed?/		o comp	oletion of ca	vailable ause of
Vital	/sician s certifi director,	To Be	25. Was case referred examiner? 1 ☐ Yes, 2 ☑		Hospital:	npatient 2 🗆	ER/Outpatient		Other	e of Deat				6 ☐ Other (Spe	- 25.3		
n of	ding Phy h. After thi funeral		27. Mann of Death	5 Pending	28a. Date of		28b. Time of injury	280	. Injury a work?	at	2	8d. Describe h			эспу)		
Divisio	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 to make the funeral director, page 2 to make the funeral director.	Certificate:	2 Accident 3 Suicide 6 Could not be determined M 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								_	28f. Location (Street and Number or Rural Route Number, City or Town, State)				ər,	
Ī	he Hospitt in 24 hour he Funera ipleted fille	Medical	(Check 2	Medical Exar	ysician: To the be niner: On the basi rse Practioner: T	s of examination	and/or investi	gation, in my	opinion,	, death occ	curred at t	he time, date a	nd place	and due to the	e cause	e(s) and mar	nner stated.
	Vom Com		29b. Signature and h	itle of certifier	11000	7	an i	29c. L	icense r	number	/ (29d. Da	te signed (Mor	oth, Day	y, Year)	
	2 M		30. Name and address			,	23a) (Type, Pr	int)	/ (1 600	ノ			2/0/1	<u> </u>	•	
	State	2	Mahesh 31. Date filed (Month,		arayappa 32. R	M.D. gistrar's Signat			shor	e Dr	Sal:	isbury	MD 2	21804			
	Registra	9			0040 -83	new	p. 4	arked									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FLORENCE DEC. McATEER BARGER 2010 6:15 A^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 M 2 X F Months Hours Min. (Month, Day, Year APRIL 7, 1 NEW JERSEY Director Yrs 142-36-4276 64 Usual Residence of Decedent 28a-f shov 10a, State 10b. Count 10c. City, Town or Location within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2X No DELAWARE SUSSEX SELBYVILLE ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 36383 PEPPER ROAD 19975 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. ò þ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: WHITE "natural" 3 Widowed 4 Divorced Specify: Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) the ARTIST COMMERCIAL ART Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve ည Page 1 and 2 should be ment of Health and Menta ARTHUR SCHMIDT FLORENCE TROUT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SCOTT E. BARGER/HUSBAND 36383 PEPPER RD., SELBYVILLE, DE 19975 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State 4 Donation Other (Specify) CREMATORY OF DELMARVA: 12/6/10 DELMAR, DELAWARE Signat 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each li me dear. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a nsequence of or Attending Physician: The law requires that the death certificate be executed the attending physician and burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ been signed by the atte should be detached for in the past 12 months? Day Year Pregnant at time of death 9 Unknow Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy after death.

Director: After this certificate 1 Yes 2 No 1 Yes filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 은 1 Yes 2 X No 1 Inpatient 2 DER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Dealt 28a. Date of injury (Month, Day, 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying furse Praytioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check 3 29b. Signature and title of certified 29d. Date sid ned (Manth. Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person

Year)

0

31. Date filed (Month, Day,

mpleted cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

المساماغية

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Amended items #20b&20c, WCHD, Certificate of Death SU, 1.4.10 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Diane T. Banks December 33. 2010 2210 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico lisbury Rehabilitation + Nursino Ctr lisburg If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign MD . Social Security Number 7. Age (In vrs. last bi **Funeral** 1 □ M 2 🛛 F Months Director 214-46-3978 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Wicomico Salisbury MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 133 Shamrock Drive 21804 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 XNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: SpecifBlack 3 Widowed 4X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Retail Sales Ames Dept. Store permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Rosa Lee Norfleet Richard Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charleita Stanley/Daughter 133 Shamrock Dr, Salisbury, MD 21804 20b. Place of Disposition (Name of Flower Place) 20a Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State MD Calvary UM Cem12-29-2010 Fruitland, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 917 W. Ineral Space Licens Isabella St. Bennie Smith Salisbury, Funeral Home Salisbury, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Caused Final Physician/ ance disease or condition resulting in death) un Medical Due to (or as a cons - vence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause Enter Underlyin Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p for use as IF FEMALE: s, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown 9 Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 X Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has 2 No Yes 2 X No 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ပ 1 Tes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA n 24 hours after death.

Refuneral Director; After the pleted filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 only one) 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert

Registrar

State

30. Name and address of

JAN 0 4 2011

M.D. 30434 Mt. Vernon Rd.

completed cause of death (Item 23a) (Type, Print)

12-24-10

Princess Anne, MD 21853

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12/28/2010 Carrol Faye Coale 6:30 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Calvert Memorial Hospital/4th Floor Prince Frederick <u>Calvert</u> If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Director 577-50-6644 97 2/23/1913 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director MD Calvert Owings 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3375 Halls Creek Lane 20736 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rayner Earl Dove Eva Estelle Suit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline S. Smith/Daughter 3375 Halls Creek Lane, Owings, MD 20736 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TrinityChurchCemetery 01/01/2011 Upper Marlboro, MD 21. Signat e of peral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, Lisa M. Mounts 20736 8125 Southern Maryland Blvd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute/chronic Congestive Heart Failure with Left Pleuval Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Advanced Isinembe Myocardlopatho -4 months Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury years Atheroscleretic The law requires that the death certificate be executed Cardiovascular attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 1 ☐ Yes 2 🔀 No 9 ☐ Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cerebrovascular Insufficiency 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Arrthumbas - Permanent Pacemaker 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 10/2010 Tsen autopsy Ischemic (DIN) Obstructive Arman Disease performed? Yes 2 No 24 hours after death.

Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medical filled in by the funeral director, To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 📉 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined the Hospital Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P. Sterner MD 17245 December 28, 2010

DHMH 17 Rev 7/2009

State Registrar 19 Chesapeake Beach Road, Owings, MD 20736

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN = 2 2011

32. Registrar Signature

Gerald P. Sterner, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Jeanne Matthes Cosby 2010 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Sunrise Senior Living Severna Park Anne Arundel 8. Date of Birth
(Month, Day, Year)
Nov. 04,1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F 89 Pennsylvania Director 154-18-4071 Usual Residence of Decedent show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 41 West McKinsey Road, Apt. 123 B 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ <u>Teacher</u> Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ethel Caulk Charles Matthes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a tant: If item 27 is John Cosby / Son 93<u>0 Dunellen Drive</u> Towson, MD 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State December Metro Crematory, INC Baltimore, MD 4 Donation 5 Other (Specify) 2010 Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral Service Licensee 495 Ritchie Hwy, Severna Park 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final CEREBROVASCULAR DISEASE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Dav Year Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FIBRILLATION 1 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an After this certificate has autopsy 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Hospital or Attending Physician: Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident
Suicide Investigation within 24 hours after deat To the Funeral Director: completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Opertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)
JAN 0 4 2011

Veterans

Hwy millerisule

10-10147 Lynette Copper Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Lynette Copper		1- For State	State of	Maryla		artment o			Mental H	lygiene	201	0 42905
Physiciar		Registrar 1. Decedent's Name (First, I	Middle,Last)		Ce	rtificate o	Deal	<u></u>		2. Date of De	Reg. No.	3. Time of Death
Medical Examin		Lunett	-	eni's	e C	opper	^			Month Decembe	Day Year er 31, 2010	
		4a, Facility/Name (if not inst	itution, give st		mber)		4b. City,		cation of Deat	n e	4c. County of	Death
Function	4	6198 Old Trappe F 5. Social Security Number	6. Sex		7. Age (In yrs.	last hirthday)	Easto	ler 1 Year	If Under 24Hrs	R Date of B	Talbot	9. Birthplace (State or
Funeral Director	1	0 000		2 V F		_	Month		Hours Mir			Foreign Mary land
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any .	Ī	10a. State 10b. Cou		_	10c. City	, Town or Locat	tion					10d. Inside City Limits
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or 28a-f show	5	10e. Street and Number	/		1		10f. Zip	Code	,		10g. Citizen of Wha	1
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hours after natural",	<u>8</u>	15. Decedent's Education	Specify only h	Dates: nighest grad	e completed)				n (Give kind of o		16b. Kind of Busi	iness/Industry
36 n 72 h n ra h ical E	Completed	Elementary/Secondary (0	12)	College (1-	4 or 5+)			_		(-	7 .	
-0036 I within 72 gjene. ther than "	<u>Ē</u>	17. Father's Name (First, Mi	idle Last)	d		Main	ten	ance	Mother's Name		Maiden Surname)	rial Service
21215-0036 uld be filed within 72 hours afte Mental Hygiers matural", sevent, the Medical Examiner	26	Grego		COP	Per			"	Fait	-6 E	lamer	
Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. or other traumatic event, the Medical Examiner must be notified at once.	اء	19a. Informant's Nam elai	ions ip (Type	, Print)		19b. Mailin	g Address	(Street a		Rural Route Nu	mber, City or Town,	State, Zip Code)
MD and 2 sho alth and m 27 is	-	Gregory	Co	pper	Los	294	40 H	0/140	aK Rad	10-Ea	Ston, Ma	ryland 21601
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altimore, mit. Pages 1 a partment of He portant: If its		4 Donation 5 Othe			Pa	radise			-	8/11	Trappe	Maryland
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and by Important: If tien 27 is in injury or other traumatic.	1	21. Signature of Funeral Ser	// Ce Licensee	1/11	IN The state of th	H.	enry	Address of	ral Ho	St. Ca	A.	
Physician	\forall	23a. Part I. Enter the disease	, or complica	tions that ca	used the death	. Do not enter t	he mode o	<i>UGS h i</i> of dying, su	ingtoru ich as cardiac c	or respiratory ar	Mbridar rest, shock, or Hear	t Approximate Interval
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ZAAIIIIIEI	1	or condition resulting in deat	h) Due	to (or as a	consequence o	of):						
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Box 6876 e death certificate the attending phy ed for use as the l	Fuysician/m	1 Yes 2 ✔ No 9	Unknown	=		atri 5 Ot	her (Spec	city)				
Division of Vital Records, P.O. Box 6876 To the Bospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the indicated of the completely filled in by the funeral director. The Completely filled in by the funeral director.	5	Part II. Other significant co	nditions cor	ntributing to	death but not r	esulting in the u	ınderlying	cause give	en in Part I.			ute to the cause of death?
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Division of Vital Records, P.O. In or Attending Physician: The law requires that the shear death. After this certificate has been signed by led in by the funeral director, page 2 should be detach		25. Was case referred to me examiner?	dical Hosp	ital: , 🗀 ,		5D/0-4-4		I Out	Death (Check			-
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Division or spiral or Attending in the read in the read in the filled in by the functions of the functions o		4 Homicide	etermined	(Specify)	Local Stree	et				or Town, 9 6198 Old Tra	ppe Road, Easto	n, MD
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To the He within 24 To the Fu complete	2	29b. Signature and title of ce	and	manner sta				. License n				(Month, Day, Year)
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		30. Name and address of per	son who com	oleted cause	of death (Item	123a)	Щ.					
		Victor Weedn MD		tant Med	ical Examir	ner 900 W	. Baltim	nore Stre	et, Baltimo	re, MD 212	23	
Stat Registra		31. Date filed (Month, Day Ye	2011	32 Reg	istrar's Signati	bay	4					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 29 3010 Physician/ Month DE 2128 M Mary Gertrude Wade Chandler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death PRINCE (SEORCE'S PRINCE COELRGES CHEVERLY HOSPITA2 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Funerai 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Days Hours 3-24-1930 Maryland 80 Director 220-28-6492 Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 XYes 2 No Maryland Charles Waldorf 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a "natural", or items 23: 14720 Bassford Rd 20601 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Nidowed 4 Divorced Black Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Aide Transportaation Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 should be Anna Wade Booth permit. Page 1 and 2 should Department of Health and M Important. If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2870 Perry St.N.E.Washington D.C. Joyce Chandler/Daughter 20018 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St.Marys Cath Ch | 1/8/11 Bryantown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Funeral Home Pa, Aquasco MD 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ MOTOR VEHICLE ACCIDENT WITH MULTIPLE INVORIES disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending housing and Cause (Disease or linjury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 1 Yes 2 9 Unknown ate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 TYes 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 \square No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred HICLE DID NOT VIELD RIGHT OF WAY 1 ☐ Natural 2 ☑ Accident injury work? 1 ☐ Yes 2 ☑ No 5 Pending DECEMBER 29 2010 1621M Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined City or Town, State) SB LECK AT COMMENT GREEN STREET Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011

RBIO

Registrar

255 ROCKVILLE

egistrar's Signatur

ROCKVILLE MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SALVALOR SYLVESTER

JAN 0 5

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Derimber HOWARD LEE COLEMAN, SR. 1525 M 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Hospital vemoriai albo at stor Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 **X** M 2 □ F Min. Hours 215-16-3465 3/12/1923 Country) **Director** MARYLAND Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No MD CAROLINE PRESTON 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21370 SKELETON CREEK ROAD 21655 USA should be filed within 72 hours after death vand Mental Hygiene.
is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates. 1943— 1945 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 OWNER TREE SERVICE Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 EFFIE COVEY ROCKWOOD F. COLEMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MYRTLE L. COLEMAN, WIFE 21370 SKELETON CREEK ROAD, PRESTON, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JUNIOR ORDER CEMETERY 1/5/2011 PRESTON, MD 21. Signa Name and Address of Facility
ELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. FELLOWS, HELFENBEIN & NEWNAM FUNERAL 1 200 SOUTH HARRISON STREET, EASTON, MD mu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of peach line. Approximate Interval Between Onset and Death Immediate Cause (Final BILATERAL PNERMONIA Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SEPSIS Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Dire to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 12 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No After this certificate 2 1 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No မ Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural n 24 hours after death.

e Funeral Director: After the furthe further of the further the further the further the further of th 5 Pending work? 1 \(\subseteq \text{Yes} 2 🗌 No 2 Accident
3 Suicide Investigation To the Hospital or Atterwithin 24 hours after der Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) robust holter D0059487 TLS 12-28-2010 10+VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN BOTSIS 219 SOUTH WASHINGTON STREET, EASTON, MD 21601

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN 0 3 2011

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN 0 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20°10 14:56 PM David F. Coe, Jr. Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Worcester <u> A</u>tlantic General Hospital Berlin, MD 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 👿 M 2 🗆 F Months Hours Min. Director 179-24-0198 Pennsylvania Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Tes 2 No DE Sussex Dagsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 30742 Long Leaf Road U.S.A. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 1951 -55 Specify: White 3 - Widowed 4 - Divorced Completed Year or Dates. the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene.
s marked other than "r
umatic event, the Mec Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Manufacturing Stress Reliever Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ t. Page 1 and 2 should be trent of Health and Ment tant: If item 27 is marked jury or other traumatic e David Friend Coe, Sr. Dorothy Elva Howley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30742 Long Leaf Road, Dagsboro, DE 19939 Shirley M. Coe / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place)
Delaware Veterans
Memorial Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/04/2011 Millsboro, DE 22. Name and Address of Facility Parsell Funeral Enterprises Signature of Funeral Service I censes 34874 Atlantic Ave., Ocean View, DE 19970 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) neumonva Medical Due to (or as a consequence of): ^fExaminer Sequentially list conditions, Examine If any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury Dusito (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I autopsy performed? Yes 2 No 1 ☐ Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 🔀 No Other: မ 1 🗌 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License numbe 29d. Date signed (Month, Day, Year) o mip MID 10064120 12/27/2010 Seme and address of person who completed cause of death (Item 23a) (Type, Print) Drive Berlin MD egistrar's Signatur State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Kent James Carson December 31 1145 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Peninsula Regional Medical Center Salisbury If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours 1⊠M 2□ F Min. Director 130-40-3961 April_ 5, 1949 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, 11 Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🙀 No Director DE Sussex Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19940 by Funeral 8887 Blackbird Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 No Specify Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) mason construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ James Walter Carson Nancy Wheeler Mack 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1</u>9940 Sharon L. Carson (wife) 8887 Blackbird Road Delmar, DE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva Jan. 4, 2011 Delmar, Delaware 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Short Funeral Home Short Funer Short Funer 13 East Grove Street Delma 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Delmar, DE Approximate Interval Between Onset and Death MINUTES Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an certificate has li rector, page 2 s performe 1 □Yes 2 ☑No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 12 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation ours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

within 24 hours a

To the Funeral I

completely filled To the Hospital State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FABRICIO ALARCON, 505-A West Market St, George town, DE 19947 32. Pegistrar's Signature 31. Date filed (Month.

Registrar

29a. Certifier

29b. Signature and title of certifier

2 Medical Exa

Medical

t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Ci 000 5514

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Harry 3. Time of Death Frederick Cheeseman Jr. Month /2 Year Medical 10 0240 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ballisba Dicomico Funeral If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) New York 1 X M 2 F Director 222-28-8066 (Month, Day, Year) 12/07/1944 66 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Maryland Wicomico Delmar 1 X Yes 2 No 10e. Street and Number 10f. Zip Code Funeral 10g. Citizen of What Country? 800 E. Chestnut St., "302 21875 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 2 Merchant Yes. Give Black, White, etc. 3 Widowed 4 Divorced 1 Yes 2 No Specify: Completed Marines Year or Dates Specify: white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) truck driver distribution Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Harry Frederick Cheeseman Sr. Frances Otis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 E. Chestnut St., 302, Delmar, MD 21875 Loriann Cheeseman/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Anatomy Gifts Registry 12 31 10 Hanover, MD Signature of Funeral Service Licenses 2 HOTTOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Physician/ Interval Between Onset and Death PSIS Medical Due to (or as a consequence of): Examiner KENAL DICEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last ENCEPHALO PATHIX Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death Yes 2 No 5 Other (specify) Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed Yes 2 Division of Vital 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 - No Certificate: To 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIRZA State 32. Registrar's Signature JAN 0 3 201 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Monthec 27, ^{Pay}2010 John Drummond 10:45 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frostburg Allegany 19120 National Highway NW 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) MD Min. 1 □ M 2 □ F ^{Ye} 1918 Hours ′Mar²2 Director 214-07-3879 92 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 10a. State rms 23a or 28a-f sho must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Frostburg MD Allegany 1 □Xes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19 Green Street 21532 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced WWII white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Supervisor Frostburg State Univ. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Dora (Dickey) Drummond James T. Drummond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Royte Number, City or Town, State, Zip r 19120 National Highway NW Frostburg MD 21532 Polla Horn Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗔 Removal from State Frostburg Memorial Park Frostburg 4 Donation 5 Other (Specify) MD 22. Name and Address of Furieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one caus on each line. Approximate Interval Between Opent and Death Immediate Cause (Final Physician/ Pb disease or condition Medical resulting in death) Examiner ERIOS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death
Unknown Dav Year signed by the at Id be detached for Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of nin 24 hours after death.

the Funeral Director: After this certificate has npleted filled in by the funeral director, page 2 s page 2 autopsy perform death? 1 Yes 2 No Yes 25. Was case referred to predical funeral director, Be 26. Place of Death (Check only one) examiner? 1 🗆 Yes 2 1 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 27. Manner Death 28a. Date of injury (Month, Day, Year) Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Latural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 3 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) MO DAGONE Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Vernon Dickerhoof Howard 2155 P M December 28, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Allegany Frostburg Village Nursing Home Frostburg If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F 84 219-14-5707 07/30/1926 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show "natural", or Items 23a or 28a-f shov MD 1 XYes 2 No Funeral Director Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 418 Columbia Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 GYes 2 □ No 1944— If Yes, Give Year or Dates: 1947 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 📝 No Specify Specify: 3 Widowed 4 Divorced 1947 White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Laborer Beverage 7 Is marked other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Eva dickerhoof ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trai once. 418 Columbia Street, Cumberland, MD A. Jane Dickerhoof/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Vet Cem @ Rocky Gap 01/03/2011 Flintstone, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final AKKINSONISM **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncomplied Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate ! 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide To the Hospital o within 24 hours af To the Funeral Di 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12690 DECEMBER 29 2010 Cot 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., Harjit S. Sidhu, 925 Bishop Walsh Road, Cumberland, MD

DHMH 17 Rev 1/2001

State Registrar

and the

✓ 32. Registrar's Signature

10-10115

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Robert C. DeLong	1- For State Registrar	tate of Marylar		rtment of <i>ificate of</i>		d Mental	Hygiene	Reg. No. 20	10	12914		
Physician/ Medical Examiner	1. Decedent's Name (First, Mid	dle,Last) LES DeLONG					2. Date of Do Month Decemb		ear	3. Time of Death 1411 hrs		
	4a. Facility Name (if not institut Western Maryland H		ber)	1	4b. City, Town, or Cumberland			4c. County Allegar				
Funeral	5. Social Security Number		. Age (In yrs. las	st birthday)	If Under 1 Yea	r If Under 24		Birth (MM/DD/YYY	(Y) 9. Birth			
Director	218-64-8394	1 M 2 F	5	7 Yrs	Months Day	s Hours	Min. 04/26	6/1953	Foreign Cou	ntry) MARYLANI		
, any	Usual Residence of Decedent 10a. State 10b. County	<u> </u>	10c. City, T	own or Locati	on					10d. Inside City Limits		
Maryland 28a-f show any d at once.	MD ALI 10e. Street and Number	LEGANY	C	UMBERLA	AND 10f. Zip Code			10g. Citizen of V		1 Yes 2 No		
the Maryland a or 28a-f sh tified at once	13725 BEDFORI	ROAD, N.E	•		2150	2		U.S.		u y r		
6, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Titem 27 is marked other than "natural", or items 23a or 28a-f shoot r traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director.	11. Marital Status 1 X Never Married 2	Married Armed Ford	dent Ever in U.S ces?		s Decedent of His es, specify Cubar				ce - America ite, etc.	an Indian, Black,		
s after dea ral", or i		1 X Yes ivorced If Yes, Give Year or Dates:	173-No	1 1	Yes 2X No	specify:		Specify:	WHI	HITE		
fours a fortunation of the control o	 Decedent's Education (Sp Elementary/Secondary (0-12 	ecify only highest grade			t's Usual Occupat ost of working life			16b, Kind of B	usiness/In	dustry		
5-0036 ed within 72 hour stygiene. other than "natu the Medical Exan Completed	12	, 51 5.7	SELI	-EMPLOYI	ΞD		CARI	CARPENTRY				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than event, the Medica	17. Father's Name (First, Middle CHARLES NELSO						me (First, Middle VIRGINIA	e, Maiden Surnam	e)			
Should be fill and Mental I is marked natic event,	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailing	Address (Stree			umber, City or To	wn, State,	Zip Code)		
ore, MD 2 es 1 and 2 shoul of Health and N if item 27 is in her traumatic	VALERIE DeLOR 20a. Method of Disposition			ace of Disposi	ition (Name of cer		Date	RLAND, MI 20c. Location		502 own, State		
Baltimore, cemit. Pages I an Department of Hee Cappartment of Hee Cappartment: If iten injury or other tr	1 Burial 2 Crematic		Otato	ematory or oth IBERLAN	erplace) DCREMAT	ERLAN	ND, MD					
Baltimore, MI pernit Pages I and 2 s Department of Health a Important: If item 27 injury or other traum	21. Signature of Funeral Service	Licensee Licensee)		ame and Address		PCHURCH	FUNERAL BERLAND,	HOME,	P.A. 21502		
Physician	23a. Part I. Enter the disease, of failure. List only one caus	r complications that cau	sed the death. [Approximate Interval Between Onset and		
M∘ci ≟xaminer	Immediate Cause (Final diseas or condition resulting in death)	I be a section of the sections			ovascular Dis	ease				Death		
	Sequentially list conditions,	b										
ted Insit Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	С								<u> </u>		
cuted md transit	events resulting in death) Last	Due to (or as a co	onsequence or):									
iO, e be executed ysician and burial - transit	UNPENDED	AMENDED						Lanca				
Sox 6876(leath certificate e attending phy for use as the by ysician/M	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 1 Live birt		2 Fet	aldeath 3 [Ectopic pre	gnancy	23d. Date o Month	of delivery Da	ay Year		
). Box 6876 the death certificate by the attending phy ched for use as the? Physician/M	1 Yes 2 No 9 Ur		4 Pregnant at time of death 5 Other (Specify) 9 Unknown									
P gg F									obacco use contribute to the cause of death? s 2 No 3 Probably 4 Unknown			
Records, P.C The law requires that freate has been signed I , page 2 should be deta			-				24a. Wa			opsy findings available impletion of cause of		
Division of Vital Records, tal or Attending Physician: The law requirers after death. La Director: After this certificate has been signed in by the funeral director, page 2 should be entification: To Be Completed								formed?	death? 1 ✔ Yes			
Vital Recysician: The lability certificate biginector, page	25. Was case referred to medic examiner?	100	atient 2 🗸 E	R/Outpatient		of Death (Che		Residence 6	Other			
n of Viding Physion 1. After this funeral direction: To	1 ✓ Yes 2 No 27. Manner of Death 1 ✓ Natural 5 Dear	28a. Date of (Month, D	Injury 2	28b. Time of In	jury 28c. Injur	y at Work?		how injury occur				
ision Attend or death. rector: by the i	2 Accident Inve	estigation 28e. Place of	of Injury - At hom	ne, farm, stree	t, factory, office b	'es 2 No uilding, etc.	28f. Location	(Street and Numb	oer or Rura	al Route Number, City		
Division o Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the funeral Certification:	4 Homicide	old not be ermined (Specify)					or Town,	State)				
Division To the Hospital or Attent within 24 hours after death within 24 hours after death completely filled in by the Completely filled in by the Medical Certificati	(Crieck Grily	Physician: To the best of aminer: On the basis of aminer state	examination and									
≥	29b. Signature and title of certific		1/3	0,0	29c, License			29d. Date sign				
2+	30. Name and address of person	who completed cause	of death (Item 2	<u>/O</u>	O.C.I	vı.⊂.		December	31, 201			
nds	Victor Weedn MD JD	Assistant Medi	cal Examine	er 900 W	. Baltimore S	treet, Baltir	nore, MD 212	223				
State Registrar	31. Date filed (Month, Pay Year,	1 Alexander	strar's Signature	arker								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ UNNO Month Year 2010 1441 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mandrin Hospice House Harwood Anne Arundel 5. Social Security Numb 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Ye OCt 21, **Funeral** 9. Birthplace (State or Foreign 193-16-7172 1 M 2 F 87 Months Days Year) Director Pennsylvania 1923 Usual Residence of Decedent 28a-f show ^{10a. State} Maryland Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Anne Arundel Annapolis 1 Tes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 44 Carriage Drive 21401 items 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? ori Black, White, etc. Š 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. White "natural" Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be Father's Name (First, Middle, Last)
Frank Elsey 18. Mother's Name (First, Middle, Maiden Surname) ည Alta Jane Zinn 19a. Informant's Name/Relationship (Type, Print)
Joseph DiNunno/husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z 44 Carriage Drive Annapolis, Maryland Zip Code) 21401 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 and Department of H 20c. Location - City or Town, State any injury or conce, 1 Burial 2 X Cremation 3 Removal from State Ft. Lincoln Crematory 4 ☐ Donation 5 ☐ Other (Specify) 1/3/2011 Brentwood, Maryland 21. Signal 22. Name and Address of Facility John M. 'Taylor Funeral Home Ineral 147 Duke of Gloucester St., Annapolis, MD 21401 a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for uses as the burial-transit burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No ပ္ 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 Tyes 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License numbe 9d. Date signed (Month, Day, Year) empleted cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

JAN 0 4

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32. Redistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 December 6:48 A DiNenna Joseph Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 4106 Cove Court Edgewater If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Days Hours Min 0976171910 Washington, DC 100 **Director** 577-34-0245 Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 72 hours after death with the Maryland Director notified Maryland Edgewater 1 ☐ Yes 2 ☐ No Anne Arundel 10e. Street and Number 10f. Zip Code 6 10g. Citizen of What Country? Examiner must be items 23a Funeral 21037 United States 4106 Cove Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ٥, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural", Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Federal th and Mental Hygiene.
27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Government 10 <u>Property Clerk</u> Be Department of Health and Mental H Important: If flen 27 is marked out any injury or other traumatic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Emila Dello Bueno Joseph DiNenna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4106 Cove Court, Edgewater, Maryland 21037 Mary Jo Rodano/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 12/30/2010 Edgewater, Maryland 22. Name and Address of Facility ^{22. Name and Address of Facility} George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 210 Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause yeach line. Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or iinjury that initiated events (of de a consequence of and -transit Exam or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of). resulting in death) Last physician a sthe burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🔲 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Hospital: 2 No မြ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 \square Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 1 🗌 Yes 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Joseph Friend,

Year)

31. Date filed (Month, Day

32. Registrar's Signature

116 Defense Highway, Annapolis, Maryland 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 SARNO 2 CV U 0115 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel . Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 D F 577-12-3108 94 Months Hours 01/13/1916 Director New York Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b, County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 🗆 Yes 2 🗀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 85 Manresa Road 21409 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔏 No Specify: 3 X Widowed 4 □ Divorced Specify White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Contracting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ralph DeSarno Rose Artigliero 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7840 Valderrama Way, Lakewood Ranch, FL 34202 James DeSarno, Jr./Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 01/02/2011 Edgewater, Maryland 21. Signative Average Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each ling. Immediate Cause (Final Physicianz settand Death 21/1C/A disease or condition Medical resulting in death) Due to r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month 2 🗆 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 🗌 Yes ျ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation Could not be 2 🗆 No 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Typ-DEFENSE Itmy ANNAPOUS MDZIYUI m ENTA 441

DHMH 17 Rev 7/2009

Registrar

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** December 29 2010 154 emirai /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederic Memorial tospita Birthplace (State or Foreign
 Country) 7. Age (In yrs. last birthday, If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** 10 M 20 F 38-874 84 Yrs. 201926 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 Is marked other than "natural", or Items 23a or 28a-f sho traumatic event, The Medical Evention is ust be notfilled at 1 ☐Yes 2 No Director 10g. Citizen of What Country? 10e Street and Number 21758 1401 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Urgeon 18. Mother's Name (First, Middle, Maiden Surname, Be (17. Father's Name (First, Middle, Last) ould be f Mental I Khia(unk) ဂ em/164 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra Theisburg MD SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Frederick 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Rollins Home 6 a14 South 110 West 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** eh000436/01 /Medical Due to (or as a consequence of): Examiner Subd Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed burial-trar Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No ned by the a P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been (24b. Were autopsy findings available prior to completion of cause of death? 9 M 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☐ No 1 Tyes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2 No 1, Npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation rittep 9:54 PM out 1 ☐ Yes 2 ☑ No 12/24/10 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide FROLETIC FVS derict Wis morial Hospital 400 Control St. Moderatifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARRE JA 3000 AUSTIN 32. Register's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State State RegistrarAmended item#1,WCHD,SU,1.3.1Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Joseph F., Delaney 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Salisbur 025101 at NICOMICO 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Months Min. 1 X M 2 🗆 F Davs Hours 0376671926 New York Director 099-18-6772 84 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 X Yes 2 □ No Maryland Worcester Ocean City 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ö or than "natural", or items 23a or the Medical Examiner must be Funeral 21842 USA 195 S. Ocean Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. 11. Marital Status Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Š 1 Never Married 2 Married Yes 2 No filed within 72 hours after 1 Yes 2 X No Specify: If Yes, Give Year or Dates white Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 721 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) bartending bartender 12 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anna Emmet Joseph Delaney 19a. Informant's Name/Relationship (*Type, Print*) Barbara Celetono/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 195 S. Ocean Dr., Ocean City, MD 21842 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State St. Raymond Cemetery 12/30/2010 Bronx, NY 4 Donation 5 Other (Specify) re of Funeral Servi HOIIOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Approximate Interval Between each line Onset and Death Immediate Cause (Final Physician/ ASCVD disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ō in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death should be detached 9 Unknown Hnknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s this certificate has autonsv 2 🗌 No 2 1 1 Yes Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital No No 1 Yes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury work? 5 Pending 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one and title of certifie 29b. Signatur 29d. Date signed (Month, Day, Year) 29c. License number 163199 12/25/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOGESH 910 EASTERN VOHRA SHOFE SALISBURY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Dav Year Physician/ Doody Lucille 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** · Com Rehaby Duesi 8. Date of Birth
(Month, Day, Year)
7-11-1920 If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🛛 F Months Min. Mary land **Director** Usual Residence of Decedent Fshow 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director the Medical Examiner must be notified 28a-f 1 X Yes 2 No Salisbury Wicomico MD 10e. Street and Number b 10f. Zip Code 10g. Citizen of What Country? by Funeral 23a USA 103 Walnut Street 21801 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status 14 Race - American Indian. Black, White, etc. ō 1 Never Married 2 Married しゅみy , ームセ, // 《 3altimore, Maryland 21215-0036 If Yes Give 1 Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) John B. Parsons Home Bookkeeper permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hayman Annie Virginia Doody Thomas Richard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Oswald - Niece Arbutus Drive, Salisbury, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 1-4-2011 Andrews Epis. Cem Princess Anne, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Bounds Funeral Home asa 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cau Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) **Examiner** 0 des Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine physician and sthe burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical Division of Vital Records, P.O. Box 68760 attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death signed by the a d be detached f the g 🗌 Unknown 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 🗌 Unknown as been signal to 2 should to Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has. autopsy page performed this certificate [1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 (100 မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After injury Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the 1 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer . License numbe 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 200 MI 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER Day 28 2010 10:45 AM SHARON VIRGINIA EYLER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth Jan • 18, 1949 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 □**X**F Months Days Hours Min. MaryTand **Director** 61 219-52-2146 Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f shorex Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Thurmont Frederick Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21788 10604 Powell Road death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. "natural", or ٥ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. 3 Widowed 4 Tolvorced White Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done duning most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Banking Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Erline Keeney Roger A. Eyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10604 Powell Rd., Thurmont, MD 21788 Joey Devilbiss / Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 12/31/2010 Walkersville, Maryland Glade Cemetery Stauffer Funeral Home 22. Name and Address of Facility Signature of Funeral Service Licensee 40 Fulton Ave., Walkersville, MD 21793 23a. Part — Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a d be detached f 1 Yes 2 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27, Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 🗹 Natural 5 Pending death. 2 🗌 No 1 Yes Accident Investigation within 24 hours after deal To the Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Bertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) si went 's Han

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year

JAN

32. Regist

ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ -WING Month Day MARIE Medical 2010 Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE MARYLAND MEDICAL CONTER BALTIMORE CITY Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 🗆 M 2 🕱 F Months Days Hours Director 03/01/1932 218-26-4658 78 Usual Residence of Decedent show 10a. State with the Maryland 10b. County notified at 10c. City. Town or Location Director 10d. Inside City Limits 28a-f DE SUSSEX BRIDGEVILLE 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code Examiner must be 10g. Citizen of What Country? Funeral 23a 22147 WOODS EDGE COURT 19933 items 2 UNITED STATES Page 1 and 2 should be filed within 72 hours after death ment of health and Mental Hygiene. That if then 27 is marked other than "natural", or items ant, if item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces þ 1 Never Married 2 X Married Black, White, etc. 1 ☐ Yes 2 🗶 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify. Completed 3 Widowed 4 Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 EXECUTIVE SECRETARY MEDICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည FRANCIS ELLIS LOTTIE McMENNAMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN HIGGINS/DAUGHTER permit. Page 1 and 2 Department of Health Important; If item 27 any injury or other tr once. 9541 CHAPEL ROAD, EASTON, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State GLEN HAVEN MEMORIAL PARK 4 ☐ Donation 5 ☐ Other (Specify) 12/22/2010 GLEN BURNIE, MD 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD 21601 ERON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician BLAIN TRAUMANC disease or condition **⊬**Medical resulting in death) Due to (or as a consequence of) Examiner SUBDURAL HEMATON Sequentially list conditions, if any, reading to immediate cause. Character Underlying Examine Due to (or as a consequence or) CERTIFICATION APPROVED BY INFEDICAL EXAMINE -transit Cause (Disease or linjury that initiated events MOTUR VEHICLE and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Pregnant at time of death Day Month Year the hed 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed t should be det 23e. Did tobacco use contribute to the cause of death? þ HEART FAILURE Completed 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION 24a. Was an 24b. Were autopsy findings available page 2 s Jas autopsy prior to completion of cause of performed?

Yes 2 No death? certificate 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 🗌 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) funeral Certificate: 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of After 28c. Injury at 28d. Describe how injury occurred 1 🗌 Natural 5 Pending injury within 24 hours a er death.

To the Funeral Director At 11-1-2010 0931 the Accident Investigation 1 Tes MOTOR VEHICLE CLASH 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined STREET Medical DUPONT HIGHWAY RT13 DOVOR PERMYE 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNIV MARILAND MEDICAL 20 DENVILLE MYRIE 622 South GREENE ST. BALTIMORE 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 21 2010 Registrar

Amend Items 25,27,28a-1 per me,917,07/15/2011dm All Copies Are Legible.

Amend Items 23artil,25 per me,816,06/20/2011dm Reg. No. 2 | | | | | For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Decen Day Year 20/3 Physician/ 0913 AM ber Estelle Grace Fisher Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Hospital Rockville 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖼 F Months Days Hours Nov. 21, 1932 Maryland 79 **Director** 219-36-4476 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland ıral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No Rockville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 9701 Medical Center Drive 20850 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Black. "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry oe filed with: *†al Hygiene. '*er than "r (Specify only highest grade completed) $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 11 \end{array}$ College (1-4 or 5+) Own Home Homemaker Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file rand Mental Fis marked of ည Grace Jackson Williams Frank F. Williams injury or other traumatic . Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13112 Mill Haven Place, Unit O, Germantown, MD 20874 Priscilla M. Dunston/Daughter permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other tonce. Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery framatery or other place)
Cemetery 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Jan.8,2011 Germantown, Maryland Molesworth-Williams, P.A., Funeral Home Damascus, Maryland, 20872 23a. Part 1. Inter the disease, or complications that cause shock, or heart failure. List only one cause on each lin that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner HEDICAL EXAMINER Due to lor as a consequence of If any, tracing to immedia cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed APPROVED BY that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): CERTIFICATION Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) i signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Records, 1 Yes 2 No 3 Probably 4 Unknown Completed due to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Demente autopsy certificate has 1 ☐ Yes 2 KNo Yes 2 No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Z A NO 1 Inpatient 2 ER/Outpatient 3 IDOA မ After this funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred + Katural 2 Accident 02/11/2010 5 Pending **5:49** р м work? 1 ☐ Yes 2 🔀 No Subject fell. Division 24 hours after death. Funeral Director: A Investigation filled in by the 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 9/01 Medical Ctr. Drive, Rockville, MD determined Nursing Home Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practices: T. U. S. St. Chapter Seath Commercial the time calculated and the time can be a stated. (Check within 2 29c. License number 06062435 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 Molecular Dr. Suite 2 Rocky. He MD 20850 Sayed Elsayyed MD 32. Regi ar's Signature 31. Date filed (Month, Day State Gusun Registrar

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3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Year Farrel 2010 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number MD y Kesville CHITOIL Count If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. 857 1 M 2□F 85 Hours 579. 28. Yrs Director 03/12/ Usual Residence of Decedent the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 No Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 100 Honey Suckle Lane Funeral U.S.A.

14. Race - American Indian,
White, etc. 21532-12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: <u>გ</u> Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Letter Carrier post office 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) is marked of ဥ Charles Farrell Eleanora Boswell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Health Important: If item 27 any Injury or other tr Susan Geatz Daughter 2 Edge O wood Lane LaVale <u>Maryland</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory December 30, 2010 Cumberland Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician End Stage disease or condition resulting in death) 10014 /Medical Due to (or as a correquence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed and as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 autopsy performe certificate 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Tyes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only the 29b. Signature and title of certifier 29c. License number 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Obrecht FILLMA 710 Copper

State Registrar 31. Date filed (Menth Day Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 28f per me 9912 2-24-11 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month GINI NKL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Age (In yrs. last birthday) **Funeral** If Under 1 Year 8. Date of Birth March Day Year, 1927 9. Birthplace (State or Foreign 1 □ M 2^X F 431-36-8366 Months Hours Min Director Arkansas Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Deale Arundel 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 907 Johns Circle 20751 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔯 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Specify: White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Oil and Gas years Bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy Thurman Westbrook Evelyn Faith Hopper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael L. Franklin - Son 907 Johns Circle, Deale, MD 20751 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place. Columbia Co., Arkansas 4 ☐ Donation 5 ☐ Other (Specify) New Hope Cemetery 21. Signati Funeral Service/Licensee Kalas Funeral Home, P.A. 22. Name and Address of Facility George Hogewater, MD 21037 2973 Solomons Island Rd Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respishock, or heart failure. List only one cause on each line. Immediate Cause (Final enset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if an cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day ed by the a detached f signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Wiknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an icate has b , page 2 sl autopsy certificate 1 ☐ Yes 2 ☐ No Yes 2 N director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 🗌 No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6X Assisted Living After this 28a. Date of injury (Month, Day, Year) anner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Localio (Street and Number or Rural Route Number City or Town, State) 3913 Birdsville Rd 4 Homicide determined 24 hours at Funeral D Davidsonville, Md. Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

To the Fune

completed fi (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of con 30. Name and address of person who completed dause of death (Item 23a) (Type, Print)
Susan McVey, C.R.N.P. 705 Digital Dr., Linthicum, MD 21090 31. Date filed (Month, Day, Year) 32. Redistrar's Signature Registrar JAN 03 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number)
1487 Tenbury Common **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Anne Arundel Annapolis Social Security Number **Funeral** (In yrs. last birthday) If Unde Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 19 Birthplace (State or Foreign Country)
 Ohio ^{Yea}r) 1917 174-12-8172 1 M 2 V F Days 93 Months Hours Min. Director Usual Residence of Decedent show with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel ms 23a or 28a-f s Annapolis 1 Yes XX No Street and Number 1487 Tenbury Common 10g. Citizen of What Country? 10f. Zip Code Funeral 21401 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes **2X** No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Completed 3XWidowed 4 ☐ Divorced Specify. Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) മ Eugene Anderson Marie Abdoul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1487 Tenbury Common Annapolis, Maryland 21401 Rebecca F. Greco/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) Lakemont Mem. Gardens: 1/7/2011 Davidsonville, MD meral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 0 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one eause on each line. Approximate Interval Between Onset and Seath Immediate Cause (Final 10 Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): -transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): burial-t resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Pregnant at time of death Month Day s been signed by the should be detached 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 1 \sum Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural . .a.ural ☐ Accident ☐ S.... 5 Pending injury М Investigation 6 Could not be 1 Yes 2 No Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 2 RIV8703 29d. Date signed (Month, Day, Year) 2010 mpleted cause of death (Item TAYLOR , 445DEFENSE HWY, ANNAPOLIS, M.D. 21401

Registrar

State

31. Date filed (Month, Day, Year) 3 2011

marks

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dec 29, 2010 Margaret Ann Glascoe 13:08 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clinton Prince George's Southern Marvland Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8 Date of Righ 7. Age (In yrs. last birthday, Funeral March 10, Yell 22 1 □ M 2√X F Mary Tand 88 Director 579 22 7525 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Maryland Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20744 3437 Lumar Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3√√√ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ဂ္ Rhoda Louise Seuler Benjamin Stuart Ripple 1 and 2 should b if Health and Mer item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pnnt) Raymond Glascoe, Jr. (Son) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 4912 Dower Drive, LaPlata, MD 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Suitland, Maryland Washington National Cemetery 1-4-11 21. Signature of Funeral Service License 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 Parf 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown icate has been siç r. page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pendina Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Pr: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) ertifying Nurse tle of certific 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature, mBer 31,2010 30. Name and address of person ed cause of death (Item 23a) (Type, Print MD2073J Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 27 2GIC Month Physician/ 1351 MARY ALMERA GRENADIER rember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hemonal Eastor albo If Unde Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min. 05/12/1945 Country) 65 MD 219-42-8427 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland Director 1 Yes 2X No TALBOT **CORDOVA** MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 30297 HARRIS RANGE ROAD 21625 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 X Married land 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: WHITE 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) LIBRARY SECRETARY Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ BERNICE SLY Page 1 and 2 should be MELVIN C. RUSSELL Baltimore, Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health 30297 HARRIS RANGE RD., CORDOVA, MD JOHN W. GRENADIER, JR./HUSBAND 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date CHESAPEAKE CREMATION 12/29/2010 1 Burial 2 Cremation 3 Removal from State þ permit. Page Department of Important: If any injury or once, STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fellows, Helfenbein & Newnam 21. Signature of Funeral Service Licensee 200 S. Harrison Street, Easton MD 21601 MERCE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Unidenying Cause (Disease or iinjury Due to (or as consequence of): signed by the attending physician and d be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death 1 Yes 2 No 9 Unknown should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 🔼 Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed' 1 ☐ Yes 2 ☐ No Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) Hospital 2 No 1 Npatient 2 ER/Outpatient 3 DOA 1 Tes 잍 this (28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work within 24 hours after death. To the Funeral Director: Af 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M 125 Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTON S. Washer W. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 29 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JEAN ALISON GAUTHIER Medical DECEMBER 4:00 P M 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 239 ORCHESTRA PLACE CENTREVILLE QUEEN ANNE'S Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs **Funeral** 8. Date of Birth g. Birthplace (State or Foreign 1 M 2 X F Months Days Hours Year 1921 89 JAN 30 Director Yrs. IRELAND 123-36-6594 Usual Residence of Decedent 28a-f shov 10a. State 10b County with the Maryland Examiner must be notified at Director 10c, City, Town or Location 10d. Inside City Limits QUEEN ANNE'S 1 Tes 2 X No MARYLAND CENTREVILLE ö 10e. Street and Number 10g. Citizen of What Country? Funeral 23a 239 ORCHESTRA PLACE 21617 UNITED STATES items permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō Ď 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No 'natural", 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed WHITE Specify: Year or Dates Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ACCOUNTANT ACCOUNTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ JAMES CHRISTIE VICTORIA CAMPBELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 239 ORCHESTRA PLACE, CENTREVILLE, MARYLAND, 21617 LEO P. GAUTHIER/ HUSBAND 20a. Method of Disposition 20c. Location - City or Town, State CHESAREAKE on CREMATION 1 Burial 2 Cremation 3 Removal from State JAN.3, 4 ☐ Donation 5 ☐ Other (Specify) CENTER 2011 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licensee FECLOWS Addreffenbein & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MARYLAND, 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Fath Industrying Cause (Disease or iinjury Due to (or as a Insequence of): Examin -transit requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): ending physician a use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months?
1 Yes 2 No Month Day Year signed by the a Id be detached f 1 Yes 2 12 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy
performed?

Yes 2 No To the Funeral Director: After this certificate completed filled in by the funeral director, pag To the Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 No ပ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No. after death. Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Medical Examiner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifler 29c. License numbe 29d. Date signed (Month, Day, Year) 2146 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 2 9 3 0

		-	For State Of Marylan		tificate of D		_	Reg. No.					
Př	nysicia	n/	Decedent's Name (First, Middle, Last) Richard John Gage				2. Date of De Month	ber 24,	Year	3. Time of Dea	ath a ^M		
. E	Medic xamin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or		Decem	4c. County of	c. County of Death				
_/			9288 Hickory Mill Road 5. Social Security Number 6. Sex. 7. Age (In yrs. le	and the last rate of	Salisbur	Y If Under 24 Hrs.	0 D-4 - (D)-	Wico					
	ineral ector		5. Social Security Number 136-14-3024 0	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da 02/20/	1920	9. Birthplace (State or Foreign Country) 1920 New Jersey				
yland	f show ed at	ctor	10a. State 10b. County 10c. City, Town or Location 10d. Institute 10b. County Salisbury 1										
he Mar	or 28a- e notifi	Director	Maryland Wicollife S 10e. Street and Number	10f. Zip Code			10g. Citizen of W	1 ☐ Yes 2 Ē	No				
h with t	ns 23a nust be	Funeral	1014 Baccharis Drive		21804			USA	SA				
21215-0036 within 72 hours after death with the Maryland giene.	item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 ☒ Yes 2 □ No If Yes, Give Year or Dates. Army		Vas Decedent of His f Yes, specify Cubar ☐ Yes 2 🏿 No		ecify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: white 16b. Kind of Business Industry				
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Maryland 21215-0036 2 should be filed within 72 hours after the and Mental Hygiene.	rked oth	To Be											
Mary of 2 should salth and M	n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Robert Gage?son		Mailing Address (Street and Number or Rural Route Number, City or Tow 6475 Hummingbird Lane, Delmar, DE								
Page Tent o	Important: If item any injury or other once,		4 15 D 11 O D 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	emetery, crem	sition (Name of natory or other place 1 Memory	City or Tov	or Town, State						
Balti permit. Departin	Import any inj once.		21. Signate e of Funeral Service Licensee	22	Name and Addres	s of Facility Funeral F Hill Rd.,	Home Pr	ofession	¹ 218€	sociati	.on		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										
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Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death.	d in by the	Certificate	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At he building, etc. (Specify		eet, factory, office			ation (Street and Number or Rural Route Number, or Town, State)					
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To the			29b. Signature and title of certifier		29c. License Dears	number		29d. Date signed					
J.	X, 1		30. Name and address of person who completed cause of death (Item	23a) (Type, P	rint)								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#'s20a.b.c.PerFHPGC1-11-11cr Certificate of Death 2. Date of Death 3. Time of Death ^{Day}28, Physician/ 2010 December 4:38 \mathbf{P}^{M} Lamar Douglas Gamble Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince George's 7005 Flag Harbor Drive District Heights 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 946 1 🛛 M 2 🗆 F Months Days Hours Min. California 559-60-3955 64 Director Feb. Usual Residence of Decedent rat", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince George's District Heights 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7005 Flag Harbor Drive 20747 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces? þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Specify: nan "natural", Medi al Exar 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Government 12th Motor Vechicle Operator traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental h ပ Melvin Velmar Gamble Jr. LeeAnn Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra once. District Heights, Md. 20747 Eileen Teresa Gamble - Spouse 7005 Flag Harbor Drive 20c. Location - City or Town, State Clinton, 20b. Place of Disposition (Name of 20a, Method of Disposition Date 8, cemetery crematory or other place)

ee S Cr Maryland

Veterans Gemeter 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) <u>Maryland</u> 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ Colon Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and I-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) burial physician the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 attending p as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 1 Yes 2 Unknown detached g Unknown P.0. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe Division of Vital Records, 1 Yes 2 No 3 Probably 4 M Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 performed? Yes 2 No death? certificate Yes 1 Yes 2 No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 2 X No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 A Residence 6 Other (Specify) : After this e funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Af completed filled in by the fu death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier ann. M-64-2011 DOOTOLOZ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9200 Basil Court Suite 200 20774 Ivan Zama, Largo, Md. 31. Date filed (Month, Day, Year State

DHMH 17 Rev 7/2009

Registrar

JAN I O 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Virginia B. Gorsuch December Medical 2010 9:35 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Worcester Berlin Nursing Home Berlin 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye, June 22, I 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X F Months Hours Min. Yrs. Director 216-12-1379 T923 Maryland 87 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director MD Worcester Ocean Pines 1 ☐ Yes 2 K No (φογ Συς βημανία μα 21215-0036 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a Funeral 21811 U.S.A. 27 Harpoon Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. white 1 ☐ Yes 2 🔀 No Specify: Completed 3 X Widowed 4 ☐ Divorced Specify 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 11 Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is meany injury or other. ည Willard Banks Frances Ruark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Gorsuch (daughter) 27 Harpoon Road Ocean Pines, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Jan 3, 2011 4 ☐ Donation 5 ☐ Other (Specify) Memory Gardens Hebron, Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13 Esat Grove Street Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician colonary resulting in death) Medical Due to (or as a consequence of): Examiner (diac accuthmia Esque tially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Directors After the control of the control of the Funeral Directors after the control of the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Day 2 No be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XNo 1 Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 X No ျင 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural injury work? 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 3 🕱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 29d. Date signed (Month, Day, Year) 12 110 Lucian 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **CRNP** Savage <u>9715 Healthway Dr, Berlin,</u> 21811 Pennie MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend items 30 per dyr g911 1-20-11 yt
amend items 20a-c per fin g912-2-11-11 yt 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month OCT. Physician/ ALICE GENTRY 9:30PM M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Hours Min. Country) 1 M 2 TF Months Yrs Director 443-16-5665 89 920 TEXAS Usual Residence of Decedent and Mental Hygiene.
and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f shov
raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes XX No VIRGINIA FAIRFAX ALEXANDRIA 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 8320 WAGON WHEEL ROAD 22309 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. by 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) FT. BELVOIR ADMINISTRATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WILLIAM BUCKNER DOROTHY MAXWELL pe should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 is any injury or Attended CHARLES GENTRY - SON 8320 WAGON WHEEL RD ALEXANDRIA, VA 22309 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date T 基Burial 2 ■ Cremation 3 ☐ Removal from State **′**2–11**–**11 Falls Church, VA. 4 Donation 5 Other (Specify) National Crematory 22. Name and Address of Facility DEMAIN: FUNERAL HOME Signature of Funeral Service Licenses 520 S. WASHINGTON STREET ALEXANDRIA, VA 22314 23a. Part 1. Enter the disease, or complications that caused the bleath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final NEUMONLA Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be $\mathcal{OH}_{\mathcal{N}}$. Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav Year 5 Other (specify) Pregnant at time of death ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did.tobacco use contribute to the cause of death? Completed by cate has been sign, page 2 should be 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Yes 2 5 No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 400 1 🗌 Yes ပ ↑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 1 Natural injury work? 5 Pending 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, completed filled in by determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Sens, UND 1005 10/12/10 7124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 Molecular Dr. #206 Rockville, Md. 20850 Truong Bao 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 0 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 29, 2010 Year Mary Estelle Hunter 7:28 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 M Months Days Hours Min (Month, Day, Year) Director MD 214-28-4356 86 October 11, 1924 Usual Residence of Decedent shov 10a State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No MD Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1805 Crofton Court 20678 permit. Page 1 and 2 should be filed within 72 hours after death very bepartment of Health and Mental Hygiene. Important; If item 27 is marked other than "navier any injury or other terms." 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc. δ 1 Never Married 2 Married Black, White, etc. Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Hotel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ **Buck Chase** Addie Chase 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1805 Crofton Court, Prince Frederick, MD 20678 Sandra Hunter - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cheltenham Veterans Cem. | January 12, 2011 | 4 Donation 5 Other (Specify) Cheltenham, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sewell Funeral Home, P.A. Blady 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Atheroscienotic Cardiovascular disense Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hypertensi've Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year ed by the 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Congestive Heart Failure with HepaticCongestion 1 Yes 2 No 3 Probably 4 Unknown Seizure clisorder 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed death? 1 X Yes 2 ☐ No Nephroscienosis Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 🗷 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 🔀 Natural work? 5 Pending s after death.

I Director: Afted in by the further □ Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопріете Defitying regardless to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 2 To the

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Church 82 Registra s Signature JAN - 4 shit

C

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

50653

GYAN

oad

C. SURANA

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MARY LOUISE HENDERSON 10:00P M Medical DECEMBER 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death KENT 3141 RIVER ROAD MILLINGTON 6. Sex If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗶 F Months Min. Hours (Month, Day, Year) Director Yrs. 221-20-0712 DELAWARE Usual Residence of Deceden ems 23a or 28a-f show ir must be notified at 10a, State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Xyes 2 No DE **KENT** DOVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 49 ROOSEVELT AVENUE 19901 UNITED STATES death v Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Examiner Black, White, etc. ò þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 **X** No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 Divorced Specify Completed Year or Dates WHITE Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 8 MANAGER RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file Ith and Mental I 27 is marked of traumatic eve ည UNKNOWN GERTRUDE BIDDLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. WYNONIA PORTER / DAUGHTER 3141 RIVER ROAD MILLINGTON, MARYLAND 21651 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) FELLOWS CEMETERY | 01/03/2011 CAMDEN, DELAWARE 21. Signature of Funeral Service Lice 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND HOME, 21620 23a. Part 1. Enter the disease, or corapitations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death
YEARS Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-1 Physician/Medical Box 68760 38 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 Yes 2 X No ō Pregnant at time of death Month detached g 🗌 Unknown P.O. þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, CONGESTIVE HEART FAILURE, DIABETES, HYPERTENSION Completed 1 Yes 2 No 3 Probably 4 X Unknown plnods 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼No 24a. Was an BREAST MASS_THAT WAS LIKELY MALIGNANCY BUT WITHOUT autopsy page performed? Yes 2 X No PATOLOGIC DIAGNOSIS, Division of Vital funeral director, 25. Was case referred to medical a 26. Place of Death (Check only one) examiner? 2 XNo 1 🗆 Yes Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Image: Institute of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Image: Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day

11/

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATTHEW KING 120 SPEER ROAD CHESTERTOWN, MARYLAND 21620

. Registrar's Signature

D0064388

29d. Date signed (Month, Day, Year)

DECEMBER 28, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Stata Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of I <i>rtificate of</i>		ental Hygien Reg. N		42937
	Physic /Medi		1. Decedent's Name (First, Middle, La Raymond Rowell I	ledrick					9, 201	
į	Exami		4a. Facility Name (If not institution, given			4b. City, Town, o	or Location of Death		c. County of D	
			Hill Haven Nursi			Adelphi				George's
	Funeral Director		234-42-9958	Sex 7. Ago	e (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea)ec. 20, 1	929 W	Birthplace (State or Foreign Country) est Virginia
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary I sh	ţ	Maryland Prince	George	Riverda1	0				1 □ Yes XX No
	h the	Director	10e. Street and Number	deor ge 3	Kiverdai	10f. Zip Code		10g. C	itizen of What	t Country?
	th wil	a	6825 Ingraham Str	eet		20737		US	Α	
92	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, if w Medical Examinar must be notified at	/ Funeral	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent I Armed Forces? 1 Yes 2 N	10		Hispanic Origin? (Spec an, Mexican, Puerto F Specify:		14. Race - A Black, W	merican Indian, /hite, etc.
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7	withi iene than	dmo	Elementary/Secondary (0-12)	College (1-4or 5	Estim		<i>a)</i>		ooring	C2105
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Mary	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street	and Number or Rural	•	or Town, Stat	e, Zip Code)
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Бант	permit. Pages Department of I Important: If it any injury or o		`4 □ Donation 5 □ Other (Specify	N) Memoral from State	Pine Hill	Cemeter	v 1/4/20	011 Bra	ndywine	e. WV
<u>3</u>	permit. Depart Import any inj		21. Signature of Funeral Service Licer	1990	22	Name and Addre	ss of Facility Rob	ert E. Ev	ans Fur	neral Home
_	다드 등 리		Y COUNTY		1	6000 Anna	apolis Roa	d Bowie,	MD 2071	15
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not ente	er the mode of dyin	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between
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8	- 01 W	Medi								
.O. DO.	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. with Puneal Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	P ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	,		23d. Date of Month	delivery Day Year
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ž	quire an sig uld b	pa	Allemia Mu	hjactoria	l'eitale	94		1 ☐ Yes 2	2 No 3 🗆	Probably 4 Unknown
2	aw re	plet	Hypothyacicles	m . Urinay	u Tract I	refection		24a. Was an	24b. Were	autopsy findings available
	The I	Completed	Electrolyte Ab;				hisis	autopsy performed?	prior t death	to completion of cause of ?
	ctor,		25. Was case referred to medical examiner?	o (moderic	y venen.	3 (NIDIAL	26. Place of Death (0 101	03 20110
	hysic this call dire	၉	1 ☐ Yes 25 No	The state of the s	t 2 ER/Outpatient	3□ DOA Othe	er: 4 Nursing Home	5 ☐ Residence	6 □Other (S	pecify)
	ending Path. or: After the funera	atlon:	27. Manner of Death 1		Year) 28b. Time of Injury	28c. Injury Work M 1 🗆 Y	/ at 28 ⟨? Yes 2 □ No	d. Describe how inju	ury occurred	
	tal or Att rs after de al Direct ed in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, stre (Specify)	et, factory, office	28	f. Location (Street a. City or Town, Stat	nd Number or e)	Rural Route Number,
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6	Vith Com		29b. Signature and title of certifier	/		29c. License			ate signed (Mo	2010
1	12		30. Name and address of person who c		ath (Item 23a) (Type, P	Print)	# R 107			d. 20182
(1)	Stat	e	31. Date filed (Month, Day, Year)	32. Begistrar	's Signature		T 10102	ריע אוו איז	14 ONIC	7. 20187
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Vear 2312 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 213-54-5587 1 - M 2 X F Months Min Washington, 64 **Director** Nov. Usual Residence of Decedent 10a. State 10b. Count the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 424 Second St. 21403 death v 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force þ 1 Never Married 2 KM Married Black, White, etc. 1 ☐ Yes 2 😿 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced White Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Senior Underwriter Mortgage Banking other traumatic event, Be Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other trainment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Morris H. Hansen Mildred Latham 19a. Informant's Name/Relationship (Type, Print) 3b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 424 Second St. Annapolis, Maryland 21403 Michael Brent Hare/husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 🙀 Cremation 3 🗍 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 01/03/2011 Baltimore, Maryland Signatur heral Service any in 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition INVASIVE SQUAMOUS CELL MONTHS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Dut to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physiclan should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Ectopic pregnancy Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an nas autopsy performed' certificate 1 Yes 2 No eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical B 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) No Hospital Other: မ 1 Inpatient 2 FR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury ☐ Accident ☐ Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Direct determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35621 2010

State Registrar 31. Date filed (Month, Day, Year)

JAN 03

REAS

32. Registrar's Signature

2001 Medical Parkway

Annapolis, MD

21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Margaret Elizabeth Hawse December 2010 10:50 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6 Mallard Lane Washington <u>Keedysville</u> 5. Social Security Number 6. Sex . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Jan. 2, 1932 1 🗆 M 2 🗰 Months Days Hours Min Maryland 217-80-3942 79 Director Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho Director 1 Yes 2 No Maryland Keedysville Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 6 Mallard Lane 21756 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc þ 1 Never Married 2 Married ☐ Yes 2 🖿 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ■ No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Mabel Mozelle Mullinix Layton Daniel Walter Layton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Mallard Lane, Keedysville, Maryland 21756 Linda E. Taylor/ Daughter permit. Page 1 and 2 Department of Healt Important: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery crematory or other place) Bethesda Church Cemetery 9 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Jan.6,2011 Damascus, 21. Signature of Fune al Service Licenses Name and Address of Facility Molesworth-Williams, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Months Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): requires that the death certificate be executed Cause (Disease or iinjury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ■ No Month 5 Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death been signed by the sahould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Renal Failure 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Diabetes Mellitus autopsy performed' death? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: ည

Division of Vital Records, P.O. Box 68760 After this certificate has the funeral director, page 2 e Hospital or Attending Pl n 24 hours after death. ie Funeral Director: After t completed

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 3, 2011

itter D0047451 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Northern Avenue

Cynthia Kuttner-Sands, MD, Hospice of Washington County, Hagerstown, MD 21742

State Registrar

Certificate:

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of N	/larylan		artment of H		Mental Hygi	200		1,2911
	Division	,	1. Decedent's Name (First, Middle, Last)					2. Date of Death	g. No. U		3. Time of Death
	Physicia Medio		Esther Sarah Sim	ms H	opkins			Decembe	r Day	2010	10:24 PM
	Examir ∡	er	4a. Facility Name (if not institution, give street and number)			4b. City, Town, or		ith		nty of Death	
	Funeral		Wicomico Nursing Home 5. Social Security Number 6. Sex 7. A	ae (In vrs. la	ast birthday)	Salisbu	I ry If Under 24 Hr	s. 8. Date of Birth	Wic	omico	land Otto
	Director		- 35	95	Yrs.	Months Days	Hours Mir		91 ['] 4	9. Birthp Count Mar	lace (State or Foreign
	d ow t		Usual Residence of Decedent 10a. State 10b. County	1							7
	arylan a-f sh fied a	cto	Maryland Wicomico	1	y, Town or Loc					10	0d. Inside City Limits 1 X Yes 2 □ No
	he Ma or 28	Dir	10e. Street and Number	Sa	lisbur	Y 10f. Zip Code		146) - Oiti	£ 14/1 + 1 O	
	with t	Funeral Director	808 Gettysburg Ave.			21804	Į.		US	of What Count A	uyr
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at the Medical Examiner must be notified at	Fun	11. Marital Status 12. Was Decedent Armed Forces	Ever in U.S		/as Decedent of His Yes, specify Cubar	spanic Origin? (S	Specify Yes or No-		ace - America	
36	after ", or xami	d by	1 Never Married 2 Married 1 Yes 2 If Yes, Give	No		Yes 2 No		to filean, etc.)		lack, White, e	
9	hours natura ical E	lete	15. Decedent's Education	-		ent's Usual Occupa					
212	e. nan "r	Completed by	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or	5+)	Give k	ind of work done do NOT use retired)	uring most of wo	orking		Business Ind	
7	d with tygien ther th	BeC	12 –	·	sea	mstress			cloth:	ing ma	nufacturing
Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	다 E	17. Father's Name (First, Middle, Last) Asbury Jesse Simms Sr.					ame (First, Middle, Ma er Ellen H		me)	
ary	should and M is man		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street a	nd Number or R	ural Route Number. C	itv or Town	State, Zip Ci	ode)
Σ.	and 2 should t Health and Me tem 27 is mark tem traumatio		Donald J. Hopkins/son		482	O Nutters	Cross	ural Route Number, C Rd•, Sali:	sbury	, MD 2.	1804
Jore	ge 1 and tof H		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State	e C	emetery, crem	ition (Name of atory or other place				n - City or Tov	·
Ē	permit. Page 1 and 2 Department of Healti Imp. rtant: If item 2 any njury or other t		4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee	Sal		Cremator				oury, I	
8	Dep mp any ono		Paris H. Gommas CF	50	Ho	of Toway From H	ill Rd.	Home Profe , Salisbur	ssion Y, MD	al Ass 21804	ociation
П			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each line	d the death	n. Do not enter	the mode of dying	, such as cardia	c or respiratory arrest	1		Approximate
	hysician/		Immediate Cause (Final disease or condition	D	MEN	TIA.					Interval Between Onset and Death
-4	Medical Examiner		resulting in death) Due to (or as	a consequ	ence of):	The second secon					
		ner	Sequentially list conditions, b. Due to (or as	a consequ	anea orij:						
	uted Id ansit	dical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events								
	exec ian ar urial-tı	E	resulting in death) Last Due to (or as	a consequ	ence of):						
90	ate be	dic	d	_							
89	Sertific Iding	Ž	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome						20.1.5		
Box	eath c atter d for u	Physician/Me	in the past 12 months?	2 Fetal	death 3 🗌	Ectopic pregnancy Other (specify)			1	ate of deliver lonth [y Day Year
	t the d by the tached	Phys	1 Ves 2 No 4 Pregnant a 9 Unknown			-					
О	es tha igned be de	þ	Part II. Other significant conditions contributing to death t	out not resu	ılting in the un	derlying cause give	n in Part I.				cause of death?
rds	requir	etec									ibly 4 Unknown
Records,	e law e has b ge 2 s	Completed						24a. Was an autopsy performs			sy findings available pletion of cause of
<u> </u>	an: Th lificate or, pa		25. Was case referred to medical			26 Plac	e of Death (Che	1 L Yes 2	No	1 Yes 2	1X No
Vita	lysica iis cer direct	년 명 년	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpati	ient 2 🗆 E	R/Outpatient	Othor		Home 5 Residence	- 6 □ Ot	ner (Specific)	
0	ing Pr		27. Manner of Death 28a. Date of inju 1 1 Natural 5 ☐ Pending (Month, Da	ıry 2 y, Year)	28b. Time of injury	28c. Injury a work?		28d. Describe how			
	ttend death stor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be				es 2 🗆 No				
DIVISION	after Direction by		4 ☐ Homicide determined 28e. Place of Injubuilding, etc.	ury - At non c. (Specify)	ne, farm, stree	t, factory, office		28f. Location (Stree City or Town, S		per or Rural R	oute Number,
_	to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of	my knowle	dge, death oc	cured at the time, o	late and place,	and due to the cause	s) and man	ner as stated.	
	the H the F mplete		(Check 2 Medical Examiner: On the basis of e only one) 3 Certifying Nurse Practioner: To the	best of my	and/or investig knowledge, de	ath occurred at the t	ime, date and pla	at the time, date and pace, and due to the ca	lace, and di use(s) and n	ue to the caus nanner as state	e(s) and manner stated. ed.
	5 ± € §	ľ	29b. Signature and title of certifier		112	29c. License n	umber	29d	. Date sign	ed (Month, Da	y, Year)
		,	30. Name and address of person who completed cause of d	eath /Itam (M)	J 65	15/5		12/	5/0.	
3	m		Mahesha Thimmarayappa M.D				Dr Sal	isbury MD	21804		
	State		31. Date filed (Month, Day, Year) 32. Registra		re, lan	ike					
	Registra		DEC 0 1 2010 /2 100		4. 19pa						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Elmer Lee Harmon, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Salisbury Wicomico Peninsula Regional Medical Ctr 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 XM 2 □ F Days Hours Min. 7/77 1928 220-28-0454 **Director** 82 Usual Residence of Decedent 28a-f shov 10b. County 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester Pocomoke City X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1006 Market Street 21851 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces 1 X Yes 2 If Yes, Give þ 1 Never Married 2 X Married 2 No Army Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: "natural", SpeB9lack 3 Divorced 4 Divorced Completed Year or Date 1.951 - 53 Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene, is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the GM Auto Plant Automotive Technician 9 Be led 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 be Christine Duncan Elmer L. Harmon, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Darryl Harmon/Son PO Box 802 Pocomoke City, MD 21851 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Friendship UM Cem 1/1/2011 Snow Hill, MD 917 W. 22. Name and Address of Facility Bennie Smith Funeral Home Isabella St. Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ EREBROVAS CULAR Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Die to for es e consecuence of: cause. Enter Underlying law requires that the death certificate be executed Cause (Disease or linjury that initiated events and the burial-trar resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Por in the past 12 months? Month Pregnant at time of death Yes 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes 2 \(\sum \) No 24a. Was an has autopsy performed? Yes 2 N Hospital or Attending Physician: The الله Phours after death. Puneral Director: After this مصنائن ملم Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No မ 1 Tyes 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) s after death. completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 12/24/2010 0 62172 MD

State Registrar

DHMH 17 Rev 7/2009

SHARAD

31. Date filed (Month A), Carl 2011

1604 MARKET ST. POLOMOKE CITY MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signatur

R SATYAL, MD

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day 8:55 AM Sadie Dec 28 2010 Mae Johns 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis HealthCare -The Pines Talbot Easton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1 □ M 2 🛛 F 217-30-8293 89 05-19-1921 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits

21673

(Give kind of work done during most of working life. DO NOT use retired)

1 ☐ Yes 2 ☐ No

16a. Decedent's Usual Occupation

Homemaker

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

Trappe 10f. Zip Code

1 ☐ Yes 2 No

home

Approximate Interval Between Onset and Death

10g. Citizen of What Country?

Race - American Indian.

Black

Black, White, etc.

Someone else's

23d. Date of delivery

Day

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

Year

Month

USA

Specify.

18. Mother's Name (First, Middle, Maiden Surname)

16b. Kind of Business/Industry

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 28a-f show Examiner must be notified at ō or items 23a Sadie Johns Baltimore, Maryland 21215-0036 "natural" 7 is marked other than "nature traumatic event, the Medical permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once. 1 - For State Registrar

10a, State

Md.

11. Marital Status

10e. Street and Numbe

Talbot

15. Decedent's Education (Specify only highest grade completed)

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates:

College (1-4or 5+)

3081 Money Make Road

1 ☐ Never Married 2 ☐ Married

3 ☑ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

6

Director

Funeral

þ

Completed

Physician

/Medical

Examiner

Funeral

Director

Physician /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran attending physician for use as the buria been signed by the should be detached s certificate has be irector, page 2 sl To the hosp....
within 24 hours after deam.
To the Funeral Director: After this certificate.

P.O. Box 68760.

Division of Vital Records,

17. Father's Name (First, Middle, Last) Be မ W. Johns Maggie unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6104 Gothic Lane, Bowie, Md. 20720 <u>Geraldine Wilson / niece</u> 20b. Place of Disposition (Name of Direct Crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 01-05-11 Dover, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fine al Service Lig 22. Name and Address of Facility Bennie Smith funeral Home 426 Dover Street, Easton, Md. 21601 25a. Pert 1. Enter the disease, or complications that caused the death-shock, or heart failure. List only one cause on each line. Do not enter the mode of ding, such as cardiac or respiratory arrest Immediate Cause (Final diseese or condition resulting in deeth) MOV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 D Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ. 1 ☐ Yes Be Completed 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifls 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 508

125

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 0 3 201

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20to 9:00 AM Steven E. Jacobs Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 15 BUR MICOMICA If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** If Under 24 Hrs. 9. Birthplace (State or Foreign Min. MD Country) 1 ★ M 2 □ F Months 214-68-5287 55 Yrs **Director** 20-1955 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 No Wicomico Mardela Springs MD 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a o traumatic event, the Medical Examiner must be Funeral |11564 Old School Road 21837 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married <u>À</u> 1 ☐ Yes 2X No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: SpecifiBlack 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Forklift Operator 12 Koski of Health and Mental Hygir If item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Mary Watts Samuel O. Jacobs, Sr. スピン 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21837 Important: If item 27 any injury or other tra San Domingo Rd, Mardela Springs, Wanda Thompson/Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Zion UM Cemetery 1-8-2011 Mardela Springs, MD 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Salisbury, Home Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or feart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Metactatu Carano disase or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death page 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No After this certificate 1 Yes 2 No eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: Certificate: To Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. City or Town, State within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completed (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title of certifier 29d. Date signed (Month. Dav. Year) 863199 12/30/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OGESH VOHRA 910 EASTERN SHURE SALISBURY 21804 MD 31. Date filed (Mgn/h) Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

			Please Type or Pri					sure All Copie h and Mental Hy		•	
		•	For State State Registrar	ai yiai		Certificate of I			Reg. 1	0010	12945
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Jennie Kiermeier					2. Date of De Month	[Day Year 30.2010	3. Time of Death 11:08A м
	Examir	ner	4a. Facility Name (if not institution, give street and number) Upper Chesapeake Medic	ral (Cen:	4b. City, Town, o			4	tc. County of Deat	
	Funeral		Social Security Number	ge (In yrs. I		nday) If Under 1 Year	If Unc	der 24 Hrs. 8. Date of Bi	rth	O Dim	thulana (Cinia au Comiau
	Director		087-28-9928 1 ☐ M 2 🗓 F Usual Residence of Decement	74		Yrs. Months Days	Hours	Min. (Month, D.) May 3	0 , 1	936	NewYork
	Maryland 28a-f sho otified al	irector	NewYork Nassau			or Location lin Squa:	re				10d. Inside City Limits 1
	death with the Maryland items 23a or 28a-f sho ner must be notified at	eral D	10e. Street and Number 1140 Hempstead Tpke., Ap	ot.1	16	10f. Zip Code 1 1 0 1 (0			Citizen of What Co	untry?
) 036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 🌠 Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.	Ever in U.S	S.	13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No		Origin? (Specify Yes or No- can, Puerto Rican, etc.)		14. Race - Ame Black, White Specify: Whi	e, etc.
0 1108 0.m Maryland 21215-0036	ithin 72 hour ene. r than "natu the Medical	Complet	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 8	5+)	1 1	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired) Chool Tead	during m	_	-	Kind of Business	
110 yland 2	uld be filed w Mental Hygi narked other natic event, t	To Be	17. Father's Name (First, Middle, Last) Leonard Distefano			0002	18. Mo	other's Name <i>(First, Middle</i> gelina	, Maide	n Surname)	
Man	2 shoul th and I 7 is ma trauma		19a. Informant's Name/Relationship (Type, Print)		19b.	Mailing Address (Street	and Num	nber or Rural Route Number	er, City	or Town, State, Zip	Code NewYork
	1 and 1 and of Healt item 2		John L. Kiermeier 20a. Method of Disposition		Place of	Disposition (Name of		Date		Location - City or	in Square, Town, State
12 30	Page ment c		1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			t, crematory or other place tcremation		1-5-11	Har	nover,M	aryland
\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \	permit Depart Impor any in		21. Signature of Funeral Service Licensee Muchael & Manuello			22. Name and Addres	ss of Fac	Marzullo Road,Balt	Fu imo	neral ore,Mar	Chapel,P.A yland21214
	hysician/ Medical Examiner	5 K	23a. Part 1. Enter the disease, or convolications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) a. The Convolution are sufficient to the convolution and the convolution are sufficient to the convolution are sufficient to the convolution and the convolution are sufficient to the convolution and the convolution are sufficient to the convolution are sufficient to the convolution and the convolution are sufficient to the convolution and the convolution are sufficient to the convolution are suffined to the convolution are sufficient to the convolution are suff	e. Scle	rot	ot enter the mode of dyin	g, such a	as cardiac or respiratory a	rrest,	SE	Approximate Interval Between Onset and Death
	izi izi	al Examiner	Sequentially list conditions, if any, leading to minimediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last								
975	tificate ng phys as the	Medic	d								-
M&⊘ . Box 6	Attending Physician: The law requires that the death certificate be scror. After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the bu	_	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	2 Feta	al death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	у			23d. Date of del Month	ivery Day Year
∩, ← N ds, P.O. I	v requires that the dea been signed by the a should be detached f		Part II. Other significant conditions contributing to death b	ut not resu	ulting in	the underlying cause give	en in Pa				the cause of death?
Jenni-	n: The law re ficate has be rr, page 2 sh	Completed by	25. Was case referred to medical					1 Yes	psy ormed?	prior to death?	opsy findings available completion of cause of
Vita	ysıcıar is certil directo	To Be	examiner?	ent 2 🗆	ER/Outr	26. Plant patient 3 DOA Othe	er:	eath (Check only one) Nursing Home 5 Resi	dence	6 ☐ Other (Speci	f _V)
nei-	nding Ph ath. r: After thi e funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injui (Month, Day	ry	28b. Tir	me of 28c. Injury	/ at	28d. Describe l			
Kiermei Division of	to the Nesptral or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	al Certificate:	3 Suicide 6 Could not be			n, street, factory, office		28f. Location (S City or Tov		nd Number or Run e)	al Route Number,
天	tne Hospi nin 24 hou the Funer npleted fill	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of 2 Medical Examiner: On the basis of examiner on the basis of examiner. To the	xamination	and/or	investigation, in my opinic	n, death	occurred at the time, date a	and plac	e, and due to the c	ause(s) and manner stated.
	Vitt		29b. Signature and title of certifier Luous	2	1	29c. License		568	29d. D	ate signed (Month	, Day, Year) 30,2010
_	12		30. Name and address of person who completed cause of de Jeff rey A. Thompson M	eath (Item	23a) (Ty		lsau	peake Dr. E	301	Airmi	21014
	Stat Registra	e	JAN 2 4 2011 August A	ır's Signatu	ure	2					
DHM	H 17 Rev 7/20	na		1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Patricia Maureen Kizilkaya December 2010 7:41 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Calvert Prince Frederick . Social Security Numbe If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X**□ Days England 07/27/1933 Director 570-62-4436 77 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Calvert Maryland Lusby 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1455 Gregg Drive 20657 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. "natural", or 2 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify: White Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Corporate Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked Francis Corrigan Dora Johnson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health ar Important: If item 27 is any injury or other trau Ismail Cztin Kizilkaya / Husbard 1455 Gregg Drive, Lusby, Maryland 20657 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

Metropolitan Crematory 12/29/10 1 Burial 2 X Cremation 3 Removal from State Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licerise Rausch Funeral Home, P.A. 22. Name and Address of Facility P. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequ Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? certificate 1 Yes 2 Who Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗹 No Hospita Other: 1 🗌 Yes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? nours after death.

neral Director; Af

filled in by the fu 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier KW 12 FREDERICK PRINCE 30. Name and address of person who completed cause of death (23a) (Type, Print) 31. Date filed (Month, Day, Year)

State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Keene, Sr. Louis М Decembro Medical 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death INLBOT 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F 213-22-9719 83 Months Days Hours Min. 08/103/21927 Country) Director MD Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Talbot Easton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21601 108 North Higgins Street and 2 should be filed within 72 hours after death Health and Mental Hygiene. tem 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Armed Forces?

1 Yes 2 No 5-47

If Yes, Give 1945-47 Black, White, etc. þ 1 Never Married 2 Married Baltimóre, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 X Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) food industry meat cutter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name *(First, Middle, Maiden Surname)* Mildred Mills Jennings Mace 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 511 Regency Drive, Saulsbury, MD 21804 G. Michael Keene / son Department of Health Important: If item 27 any injury or other trong once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Capitol Crematory 20c. Location - City or Town, State . Page 1 12/25/2010 Dover, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility andep Moore Funeral Home, PA, 12 S. 2nd St., Denton, MD 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a cons duence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant g Unknown Pregnant at time of death 5 Other (specify) Month Dav Year 1 Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🌠 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Yes 2 N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 1) 8865656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUSTIN ACRO 31. Date filed (Month, Day, Year) Degistrar's Signature State Registrar DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 26, Roland Thomas King 2010 10:45 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8820 Doctor Perry Road Dickerson Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days 1 🖾 M 2 🗆 F Hours Min. July Pay, Year) 944 215-46-4746 Mary land Director Yrs 66 Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Eart: If item 27 is marked other than "natural", or items 23a or 28a-f show into or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Dickerson 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8820 Doctor Perry Road 20842 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Specify 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Plumbing 11 Plumber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Myrtle M. Poole Clarence A. King, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11796 Sierra Dr., Monrovia, MD 21770 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to Edward King / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Demoval from State Resthaven Crematory 4 Donation 5 Other (Specify) 2010 Frederick, Maryland . Signature of Funeral S 22. Name and Address of Facility Resthaven Funeral Services, 9501 Catoctin Mountain Hwy. Skkot Cody Frederick, P.A. MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 4 Onset and Death 4 years Immediate Cause (Fi addisease or condition Physician Lung Carcinoma Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or impury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year signed by the a Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 X Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an 24 hours after death. Funeral Director: After this certificate has autopsy death? ☐ Yes 2 🛭 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 10 1 🗌 Yes 2 🔀 No Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 \square Nursing Home 5 \boxtimes Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

Alan Rohrer, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

the walk with

15 West 7th Street, Frederick, MD 21701

D 37197

29d. Date signed (Month. Dav. Year) December 28, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Month Year **Physician** BLANCHE ANN KNAPP /Medical December 31, 2010 6:35 A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 20721 Miracle Drive Gaithersburg Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 69 Yrs 211-34-4022 Director Dec. 1941Connecticut Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show item 27 Is marked other then "naturel", or Items 23e or 28e-f show other treumatic event, the Medical Examiner must be notified at Gaithersburg Md. Montgomery 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20882 20721 Miracle Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: à White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ifiled within 7 I Hygiene. other then "n Elementary/Secondary (0-12) College (1-4or 5+) Beauty Consultant Cosmetics 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be find and Mental H Mildred Coon Louis Tecumseh Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ages 1 and 2 s nt of Health an : If item 27 Is r 20721 Miracle Drive, Gaithersburg, Thomas J. Knapp / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ite
eny injury or ot 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 1/1/2011 Alexandria, Va. Metropolitan Crem. 21. Sign wure if Fundral S-vice icensee 22. Name and Address of Facility Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. -004 20882 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Asystole minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner hours Hypoxia Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit days **Encephalopathy** Due to (or as a consequence of): Box 68760 attending physician Physician/Medical Glioblastoma Multiforme months the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No ŏ Month 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has ormed2 2 No certificate 1 Tyes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 유 1 🗌 Yes 2 No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: d in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D-67422 December 31, 2010

DHMH 17 Rev 1/2001

State Registrar

20

Thomas Johnson Drive, Frederick, Md.

21702

30. Name and address of person (Type, Print)

Yun Ho, M.D.

31. Date filed (Month, Day, Year,

46-B

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State of Maryl	•	artment of H <i>tificate of L</i>		•		
			Registrar Decedent's Name (First, Middle, Last)	06,	lineare or L	Jeani	2. Date of De		3. Time of Death
	Physicia Medic		Laura Knight				Decemb		510 2042 M
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or		h	4c, County of E	
	Funeral	-	200 Clay St. 5. Social Security Number 16. Sex 17. Age (In v)	rs. last birthday)	Annapo	lis If Under 24 Hrs	6. Date of Bir		Arundel Birthplace (State or Foreign
1	Director		217-78-6459 1 M 2X F	50 Yrs.	Months Days	Hours Min.		4 ^{year} 960 M	ary 1 and
	nd how at	ă	Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Loc	cation			-	10d. Inside City Limits
	//aryla 8a-f s tified	Funeral Director	Maryland Anne Arundel	Annapo	lis				1 ☐ Yes 2 🛣 No
	a or 2 be no	io le	10e. Street and Number		10f. Zip Code			10g. Citizen of What	t Country?
	th with ms 23 must	ner	200 Clay St.		214			USA	
(0	er dea or ite	by Fu	11. Marital Status 1. X Never Married 2 □ Married 1. Was Decedent Ever in Armed Forces? 1. □ Yes 2 X No	If	Vas Decedent of Hi FYes, specify Cuba	n, Mexican, Puert	pecify Yes or No- o Rican, etc.)		merican Indian, /hite, etc.
Ö	urs aft ural", al Exa	ted t	3 Widowed 4 Divorced If Yes, Give Year or Dates.	1	☐ Yes 2X No	Specify:		Specify:	Black
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pu	tal Hyg d oth event,	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Na		Maiden Surname)	
Zla	uld be d Men marke matic	F	Albert Knight				e Brow		
Ma	12 sho lith an 27 is i		19a. Informant's Name/Relationship (Type, Print) Estelle Hyman(Sister)		g Address (Street a Clay St			r, City or Town, State, ${ m Md} \cdot 2140$. '
ore,	of Hear of Hear fitem		20a. Method of Disposition 20t	o. Place of Dispos		<u>-</u>	Date	20c. Location - City	
Baltimore, Maryland 21215-0036	t. Page tment tant: I		1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Metro C	remator	y 1-5	5-11	Baltimo	2.5%
Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee					uary, P. s, Md. 2	
П			23a. Part 1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause or, each line.			1112			Approximate Interval Between
-	h sician/ Medical	4	Immediate Cause (Final disease or condition resulting in death)	osele	rotic 1	Hear	- D1	SPASE	Onset and Death
	Examiner		Duy to or as a const	equence on:	USIDE				
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		D1	*,			
	and transi	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consi	<u>d</u> C	Desi	ty			7
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3760	ificate ig phy: as the		d						
89 x	th cert ttendir or use	ian/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of preg 1 ☐ Live Birth 2 ☐ F	etal death 3 🗌		/		23d. Date of	
P.O. Box	ne dea / the a' ched fo	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of 9 ☐ Unknown	of death 5 □	Other (specify)			Month	Day Year
O. O.	that the	by PI	Part II. Other significant conditions contributing to death but not	esulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
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Division of Vital Records,	has be	Completed					24a. Was a	sy prior	autopsy findings available completion of cause of
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VITa	ysicia s certi directo	To Be	examiner? 1 Yes 2 \subseteq No 1 \subseteq Inpatient 2	ER/Outpatient	Otho	ce of Death (Chec		ence 6 🗆 Other (Sp	
ō	ng Ph fter th ineral		27. Manner of Death 1 Natural 5 Pending (Month, Day, Year)	28b. Time of injury	28c. Injury work?	at		ow injury occurred	occity)
Sion	ttendi death stor: A / the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	home form stre	M 1 🗆 🕆	res 2□No			
Ĭ	al or A s after I Direct d in by		4 Homicide determined 28e. Place of Injury - At building, etc. (Spec		et, ractory, office		28f. Location (S: City or Town	treet and Number or . n, State)	Rural Route Number,
- , ;	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my known control of the basis of examination of the basis of the basis of examination of the basis of the	tion and/or investig	aation, in my opinior	 death occurred : 	at the time, date an	nd place, and due to the	ne cause(s) and manner stated
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	20		Uhllen R of m	5	De	605	4	12/2	8/10
	2		30. Name and address of person who completed cause of death (ite	m 23a) (Type, Pri	(695	Am	erica	21	035
	State Registra	_	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Ite 31. Date filed (Month, Day, Year) JAN 03 2011 32. fegistrar's Signature and S	natura. Apa	uks.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Claire J. Krisewicz 0730 Medical December 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5691 North Nithsdale Drive Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Months Hours 0470271940 Director 70 New Jersey 138-32-1374 Usual Residence of Decedent 28a-f show 10a. State 10b. County death with the Maryland traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 Yes 2 X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 5691 North Nithsdale Drive 21801 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 X No 1 ☐ Yes 2 X No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", any injury or other traumatic event; the Medical Exa Specify: 3 Widowed 4 Divorced Year or Dates white Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) teacher education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Jaggard Margaret Quay 19a. Informant's Name/Relationship (Type, Print)

Joseph Krisewicz/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code 569I N. Nithsdale Dr., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 12/30/2010 ²² Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 . Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death netasta Immediate Cause (Final Physician/ lomo Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ieral Director: After this certificate has filled in by the funeral director, page 2. autopsy performed? Yes 2 No Yes 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? (2 27X No 1 🗀 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 \square Pending injury work?
1 \[Yes 2 \[No \] Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours after To the Funeral Direc determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) ason who completed cause of death (Item 23a) (Type, Print)

Registrar
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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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SAUSBURY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ KIRKSEY DECEMBER 31 ^Y2010 CHRIS 6:34Р м LORENZO Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Days 1 🛣 M 2 🗆 F Hours Min. DEC. 27 Year 937 **Director** MISSISSIPPI Yrs. 422-46-1294 Usual Residence of Decedent or 28a-f show notified at shov 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No PRINCE GEORGE'S MITCHELLVILLE MD 10e. Street and Number 10f. Zip Code permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be rone. 10g. Citizen of What Country? Funeral 1101 KINGSDALE STREET 20721 USA 12. Was Decedent Ever in U.S.
Armed Forces?

1 □X Yes 2 □ No AIRFORCE
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc þ 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 X No Specify BLACK Completed 3 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) IT SPECIALIST GOVERNMENT Be and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ IDRIAN KIRKSEY INEZ MURPHY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1101 KINGSDALE STREET MITCHELLVILLE, MARYLAND 20721 SHARON KIRKSEY/WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State RIVERDALE CREMATORY 1/10/2011 RIVERDALE, MARYLAND 4 Donation 5 Other (Specify) J.B. JENKINS FUNERAL HOME, INC. ature of F he al Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final omyopa Onset and Death Physiciani azdi disease or condition Years Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and -tran Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? Month Dav Year g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral (27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation ☐ Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier DO058213 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapohi Rd Glenn Dale MD 12150 FARHAD JAMALI MD 31. Date filed (Month, Day, Year) 32. Registra 's Signature State JAN 0 7 2011 Registrar

DHMH 17 Rev 7/2009

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

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		1	For State Registrar	Otate of Ivi	iai yiai ii	•	tificate of E			Reg. No.?		2953
			Decedent's Name (First, Middle, Last)						2. Date of Dea	th	1	3. Time of Death
Physic Med			MARY LEE MOORE		R				Decembe:	r 31, 2	Year 2010	2303hrs M
Exam	ine	r	4a. Facility Name (if not institution, give str	eet and number)			-	Location of Death			ty of Death	
Funer			908 Market Street 5. Social Security Number 6. Sex		ge (In yrs. la	st birthday)	Pocomoke If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	Worce	9. Birth	place (State or Foreign
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Box 68760 death certificate b he attending physied for use as the b	, 40	la l	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome 1 Live Birth	2 Fetal	death 3 🗌	Ectopic pregnanc	у			ate of deliv	ery Day Year
. Bo	Short Andrews	35	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant a 9 Unknown	at time of d	eath 5 □	Other (specify)				ionii i	
ords, P.O. Bover the designed by the standard be detached	h. d	Ś	Part II. Other significant conditions cont	ributing to death b	out not resu	ulting in the ur	nderlying cause giv	en in Part I.				ne cause of death?
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ing Ph ing Ph inter th	1	. G	27, Manner of Death 1 Natural 5 Pending	28a. Date of inju (Month, Da		28b. Time of injury	28c. Injury work	at ?	28d. Describe h			
sion ttendi death stor: A	Cortificato.		2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Inj	un/ - At hor	me farm stre		Yes 2 No	28f. Location (S	tmot and Num	her or Pura	Route Number
Division of Vital Records, P.O. ital or Attending Physician: The law requires that the us after death. ral Director: After this certificate has been signed by itel in by the funeral director, page 2 should be detact			4 Homicide determined	building, et	c. (Specify)				City or Tow	n, State)		
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Modioal	Medic	29a. Certifier 1 Certifying Physici (Check 2 Medical Examine only one) 3 Certifying Nurse	: On the basis of e	examination	and/or investi	gation, in my opinio	n, death occurred a	it the time, date ar	nd place, and d	ue to the ca	use(s) and manner stated.
To t With To t			29b. Signature and title of certifier	inta	u	u	29c. License	number 2556		29d. Date sign		Day, Year) - 2011
BA 5			30. Name and address of person who con J.G. Santiano, 10				int)					
S	ate		31. Date filed (Month, Day, Year)	32. Registr	ar's Signati	ure	o toy	, .w 210.	J			
Regis DHMH 17 Rev 7			31. Date filed (Month, Day, Year) JAN 0 4 201	1 Ann	4	9 100	Med					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 7:45 William Henry Laisure Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chester River Hospital Chestertown Kent If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Months **Director** 523-98-6619 1968 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🛣 No Maryland Caroline Goldsboro 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 15394 Cutoff Road 21636 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 7; ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) 12 H.S. Grad College (1-4 or 5+) Termite Technician Pest Control Be Father's Name (First, Middle, Last) Charles 18. Mother's Name (First, Middle, Maiden Surname) Shuman Sharon Elizabeth West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine L. Laisure/spouse 15394 Cutoff Road, Goldsboro, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State permit. Page Department Important: If any injury or 4 Donation 5 Other (Specify) Greensb<u>oro Cementer</u> Jan. 3. 2011 Greensboro, Maryland 22. Name and Address of Facility Moore Funeral Home, P.A. 21. Signature of Eurieral Service 12 South Second Street, Denton, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician LOUIT disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner O Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year Day 5 Other (specify) Pregnant at time of death signed by the at d be detached fo 1 Yes 2 L 9 Unknown the 9 Unknown led by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 No certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Tes 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 10 Naturai work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

within 24 hours after death

To the Funeral Director: A
completed filled in by the f

State Registrar 29a. Certifier

3 🗆 29b. Signature and title of certifier

Wafik I. Zaki, M.D.

31. Date filed (Month, Pay, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3

920 Market Street, Denton, Maryland

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

31

21629

29c. License number

001

29d. Date signed (Month, Day, Year)

3

10

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month S:00A spence 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heritage Harbor Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min 033-14-1431 (Month Day Year) 8/18/1917 93 **Director** Mass Usual Residence of Decedent 28a-f show at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director other traumatic event, the Medical Examiner must be notified MD Anne Arundel Galesville 1 ☐ Yes 🛣 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 1040 East Benning RD. 20765 USA id Mental Hygiene. marked other than "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2XXNo If Yes, Give ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify. 3XXWidowed 4 ☐ Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Chester Vickery Elizabeth Pierce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Lawrence Son 1040 East Benning Rd. Galesville, MD 20765 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5 Atlantic Crematory 12/28/2010 Glen Burnie, MD 22. Name and Address of Facility Hardesty Funeral Home P.A. 21. Signature of Funeral Service Licenses any 905 Galesville Rd, Galesville, MD 20765 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 080 disease or condition Medical resulting in death) Examiner 10 Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine consequence of physician and s the burial-transit requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical neumoni attending pl IF FEMALE yes, outcome of pregnancy
Live Birth 2 Live Betal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death Yes 2 No 1 Yes 2 9 Unknown s been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law certificate has page 2 autopsy performed 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tyes 2 No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the I within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Doine MAHBOOB EI bolis MI tona 31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 (1)

		•	For State Of N State Registrar	taryian	a / Depa Cer	tificate of	Healt Deati	n and i h	імептаі ну	Reg. N	^e 2010	295	5
	Physicia	ın/	1. Decedent's Name (First, Middle, Last) Angelo J. Marini						2. Date of De Dec 26,	ath		3. Time of Death	
	Medic Examin		4a. Facility Name (if not institution, give street and number)			4b. City, Town,					c. County of Dea		101
	Funeral	-		ge (In yrs. Ia	ast birthday)	White	r If Un	der 24 Hrs.	8. Date of Bir	th	Charles 9. Bir	thplace (State or Forei	gn
	Director		578 36 8657	83	Yrs.	Months Day	s Hour	rs Min.	May 4,	1927	Peni	isylvania	_
	yland -f show ed at	ctor	10a. State 10b. County	10c. City	, Town or Loc						-	10d. Inside City Limi	
	the Mar or 28a e notifi	Dire	Maryland Charles 10e. Street and Number		WILLE	10f. Zip Code		-		10g. C	itizen of What Co		No
	th with ms 23a must b	Funeral Director	3915 Ravine Drive	F 1-110	140.0	206		0::0/0			United Sta		
3036	should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	ted by Fi	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forces? 1 □ Yes 2 ☒ If Yes, Give Year or Dates.	?	l II	Yes, specify Cu	ban, Mexi	ican, Puerto	pecify Yes or No- pecify Rican, etc.)		14. Race - Ame Black, Whit Specify: Whi	e, etc.	
212-(יי 72 אסן 72 ה :- an "nat Medic a	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or	5.1)	(Give F	ent's Usual Occi and of work done NOT use retire	e during m	nost of wor	king	16b. l	Kind of Business		
217	d withir dygiene ther th nt, the	Be Co	Elementary/Seconday (0-12) College (1-4 or Otth 17. Father's Name (First, Middle, Last)	5+)	Br	ick Layer			<i>=</i> 1		Self Emp	Loyed	
/lanc	d be file Mental H arked o	To E	Battisto Marini				18. M		ne (First, Middle, rine Scha		Surname)		
	1 and 2 should be Health and Men item 27 is marke other traumatic	8	19a. Informant's Name/Relationship (Type, Print) Mary A. Marini (wife)		Y	-			ral Route Numbe Plains, M		r Town, State, Zij 95	Code)	
more			20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	_ ce	lace of Dispos emetery, crem Cremato	sition (Name of natory or other pi D 'Y	ace)	Dec	Date 29, 2010		ocation - City or nton, Mar		
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Softice Lightsee	257					Funeral F MD 20735		Inc 6633 (Old Alexandri	a
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lir Immediate Cause (Final	ne.			ring, such	as cardiac	or respiratory an	rest,	·	Approximate Interval Between Onset and Death	
	Physician/ Medical Examiner		disease or condition resulting in death) ALZ Due to (or as		S DISE	ASE							
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a conseque	ence of):								
	icate be executed I physician and s the burial-transif	ledical Examiner	Cause (Disease or linjury that initiated events resulting in death) Last C. Due to (or as	a conseque	ence of):		-						_
09/	physicia	edical	d										
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л Э	that the	by Ph	Part II. Other significant conditions contributing to death	but not resu	ulting in the ur	nderlying cause	given in Pa	art I.	23e. Did to	obacco	use contribute to	the cause of death?	
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Keco	: The law i	Completed							24a. Was autop perfo 1 \(\sum \) Yes	rmed?	prior to death?	copsy findings available completion of cause of 2 No)
VItal	ysician s certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 XXNo Hospital: 1 ☐ Inpat	tient 2 \square f	ER/Outpatien		de acus	Death (Chec		lanca i	6 ☐ Other (Spec	(f.)	
T 0 L	ding Ph h. After thi funeral		27. Manner of Death 28a. Date of inj 1 △ Natural 5 □ Pending (Month, Da	ury 2	28b. Time of injury	28c. Inju			28d. Describe h				
JIVISION OF VITAL RECORDS,	al or Attences after deat Director: d in by the	Certificate:		jury - At hon ic. (Specify)	me, farm, stre	M 1 L et, factory, office		LI No	28f. Location (S City or Tow			al Route Number,	
	Hospit 24 hour Funera leted fille	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of Check only one) 3 Certifying Nurse Practioner: To the	examination	and/or investi	gation, in my opir	nion, death	n occurred a	at the time, date a	nd place	e, and due to the	ause(s) and manner sta	ıted.
_	To the		29b. Signature and title of certifier	Dest of my	Knowledge, G	29c. Licen				29d. Da	ate signed (Month	, Day, Year)	
	702		30. Name and address of person who completed cause of	death (Item :	23a) (Type, Pi					De	20, 2010	,	
	200		Krishan Mathur P.O. Box 1703	LaPlata	a, MD 20)646							
	Stat Registra		(ANO 3 2011	ar's Signatu	A A	arke		•					

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State of Maryland / Department of Health and Mental Hygiene

			For State State Registrar	of Maryland	-	artment of F <i>tificate of E</i>	Health and N Death	-	giene Reg. N2 0	0 52957
	Physicia	an/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Dav Y	3. Time of Death
-	Medi Examir	cal	PAUL RUSSELL MARIN 4a. Facility Name (if not institution, give street and not			4h. City Town, or	Location of Death	Dec.	20, 201 4c. County of	<u>0 1850 ^M</u>
			5902 Newhart Mill	,		Seaf				chester
	Funeral Director		5. Social Security Number 217-28-4719 6. Sex 1½ M 2 🗆 F	7. Age (In yrs. Ia:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day May 28	(Year)	Birthplace (State or Foreign Country) Maryland
	and show dat	Ď	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc					10d. Inside City Limits
	Mary 28a-f)irec	MD Dorchester			Seafo	ord 			1 🗌 Yes 2ဳ No
	with the	eral	10e. Street and Number 6347 Partride Lane			10f. Zip Code 19	973		10g. Citizen of What United	
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hiury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	Armed	s 2 🗆 No live	If	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 X No	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White
15-0	72 hou "natu ledica	nplet	15. Decedent's Education (Specify only highest grade complete	d)	(Give k	ent's Usual Occupa ind of work done d	ation uning most of worki	ing	16b. Kind of Busin	ness Industry
212	within giene. er thar the M		Elementary/Seconday (0-12) College	(1-4 or 5+)		0 NOT use retired) $0 1 ROOM$	Operat	or	Vienna	Power Plant
Maryland 21215-0036	d be filed v Aental Hyg irked other itic event,	To Be	17. Father's Name (First, Middle, Last) Otis Marine				18. Mother's Name Neda B		Maiden Surname)	
	nd 2 shouli salth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Debbie Wheedleton/N	iece	19b. Mailin 5902	g Address (Street a Newhar	and Number or Rura	Route Number	; City or Town, State eaford,	e, Zip Code) DE 19973
Baltimore,	Page 1 arment of He ant: If iter ury or oth		20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal fro 4 □ Donation 5 □ Other (Specify)	m State Doro	nce of Dispos metery, crem Cheste:	sition (Name of atory or other place Page 11.	erk 12/2	Oate 3/10	20c. Location - Cit Cambridg	ty or Town, State e, Maryland
Balt	permit. Departi Import any inji		21. Signature of Funeral Service Licensee Muhaul 7 - Gasko	W	12	Name and Addres	1.1	ramptom 632	Funeral H	
	Medical Examiner the private be executed the private and the private the private the private that the private the private that the private tha	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	o (or as a conseque	nce of):	the state of the s	, soon as carulae u	respiratory and	esi,	Approximate Interval Between Onset and Death
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	₹	in the past 12 months?	utcome of pregnance Birth 2 Fetal of gnant at time of de known	death 3 🗌	Ectopic pregnancy Other (specify)	/		23d. Date o	of delivery Day Year
rds, P.O.	equires that t een signed b rould be deta	þ	Part II. Other significant conditions contributing to	death but not resul	ting in the ur	derlying cause give	en in Part I.	23e. Did to	\sim	te to the cause of death?
Division of Vital Records,	The law re cate has bu page 2 sh	Completed						24a. Was a autop: perfor 1 \square Yes	sy prio med? deat	e autopsy findings available r to completion of cause of th? Yes 2
/ital	sician certifi	To Be	25. Was case referred to medical examiner? 1 Yes No Hospital:	Inpatient 2 🗆 E	D/O	Otho	ce of Death (Check		of diele	
on of \	nding Phy tth. ; After this e funeral c	cate: T	27. Manner of eath 28a. Date		8b. Time of injury	28c. Injury work?	4 Nursing Holat		ence 6 Other (S	Specify)
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_	ne Hospits n 24 hours ne Funera pleted fille	Medical	29a. Certifier (Check only one 3 Certifying Physician: To the be	isis of examination a	ind/or investig	nation in my oninior	death occurred at	tha tima data an	d place and due to	the causeds) and manner stated
	Voithi To th		29b Signature and title of certifier	20	M	29c. License			29d. Date signed (M	
			30. Name and address of person who completed cau	se of death (Item 2	3a) (Type, Pri	int)	BOX 17	33 C	alish.	MD 2/8054
Ī	Stat Registra	_	31. Date filed (Month, Day, Year) 32.	Registrar's Signatur	ford	New York	07/1/		7	

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ richard Miemie Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Western Mary lann Health ALLEGAN lant Social Security Number **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 ★ M 2 □ F (Month, Day, Year) Days Hours Director Yrs Country) 074-26-7313 New York Usual Residence of Deceden show nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. Nortant: If item 27 is marked other than "natural", or items 23a or 28a-f shoinjury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Allegany Cumberland 1 ☐ Yes 2 💢 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11401 Morningside Drive, NE 21502 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No 1951—
If Yes, Give 1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced 1954 White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Maintenance Engineer Corporate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Felix Miemietz Rose Kuztera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melony Files/ Friend 14401 Ruth Lane, Cumberland, MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Vet Cem @ Rocky Gab 01/03/2011 Flintstone, MD 22. Name and Address of Facility Adams Family Funeral Home, 1170 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Sater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Ssection news disease or condition < 30 min Medical resulting in death) Due to (or as a consequence of Examiner Sanguinatio Social fields list our cittle is, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and I-trar resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ r_Diomyopath Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2079 cate has page 2 s autopsy Abetes Mellitis this certificate 1 Yes 2 No Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🗌 Yes 2 \square No Accident 24 hours after deatle Funeral Director: Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [To the within 2 To the F only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) Sin person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 200 MO seorge MD elleakin Date filed (Month, Day, Year) JAN 0 3 201

State

Registrar

32. Registrar's Signature

2011

			Please amend #5 1 - State Registrar	Type or Prin Per INF 69 State of Ma			ible in I jii ent of l ate of i		re All C nd Ment		i Are L Jiene Reg. No.2	egible.	429	359
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	Examir	er	4a. Facility Name (if not institution, give NEMOTICLI HOSP)	street and number)	costan	4b. C	ity, Town, o	or Location of	Death		4c. <u>C</u>	ounty of Deat		
	Funeral Director		5. Social Security Number 6. Social Security Number 178—18—1685 1		In yrs. last birthday) Yrs.	If Un Month	der 1 Year ns Days	If Under 24 Hours		nte of Birth Ionth, Day T • 2	7,191	9. Birt	hplace (State or Intry) ISIANA	Foreign
	and show t at	or	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation							10d. Inside City	y Limits
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	with the 23a or ist be i	eral	10e. Street and Number 330 HERON POINT			101.	Zip Code 21	620			10g. Citize	n of What Co USA	untry?	
	er death or items miner m	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev- Armed Forces? 1 ☐ Yes 2 😿 N	0	f Yes, sp	ecify Cub	Hispanic Origin an, Mexican, F	n? (Specify Ye Puerto Rican,	s or No- etc.)	14.	. Race - Ame Black, White		
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2	d withi lygiene ther th	l o	12	4		IOME	MAKER		- 1 (Fine)	147-47-		N HOME		
Janc	l be file lental H rked o tic eve	To B	17. Father's Name (First, Middle, Last) REGINALD DUNDERD	ALE FORBES					s Name <i>(Fir</i> st) RISTIN			name) STROUT		
Maryland	d 2 should alth and N 27 is ma r traumat		19a. Informant's Name/Relationship (T) BENJAMIN C. TILGH			0	,	and Number of					-	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If tier Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 🙀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	20b. Place of Dispo cemetery, crer CHESAPEAI CENTER	sition (N natory o	lame of r other pla REMA 1	TON D	Date DEC. 30	. 1		tion - City or	Town, State LE, MD 2	21666
Balti	permit. Departn Imports any inju		21. Signature of Euneral Gentice Licens	1977	_ 22 F1	LLO	WS.HE	es of Facility	IN & N	EWNAL	M FUN	ERAL H	OME, P.	Α.
pode !	hysician/ Medical Examiner prival-transit	sal Examiner	23a. Part 1. Enter the disease, or compositions, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to (or as a conductor) Due to (or as a conductor) Due to (or as a conductor)	consequence of):								Approximate Interval Betw Onset and D	veen
Division of Vital Records, P.O. Box 68760	To the hospital or Attending Priysician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 moptins? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t 9 Unknown	Fetal death 3		ic pregnan (specify) _	су			230	d. Date of del Month		ear
ls, P.O	ires trat t signed b Id be deta	<u>중</u>	Part II. Other significant conditions or	entributing to death but	not resulting in the u	nderlyir	ig cause gi	ven in Part I.	2	3e. Did tob		/	the cause of de	
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ita	certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			0.11	lace of Death						
ک	g rnys er this eral di	e: To	27. Manner of Death	1 ☑ Inpatien 28a. Date of Injury (Month, Day,	t 2 ER/Outpatier		28c. Injur	y at			ence 6 ∐ w injury od	Other (Speci courred	fy)	
sion	Attending at death. Sector: Aft by the fur	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury	- At home, farm, stre	M eet, fact		Yes 2 N	28f. Lo			umber or Rur	al Route Numbe	<u></u>
<u> </u>	Ispital or hours afte neral Dire d filled in I	Medical Ce	29a. Certifier 1 Certifying Phys	building, etc. (y knowledge, death o	occured	at the time	e, date and pla	ace, and due	ty or Town	se(s) and n	nanner as sta	ted.	
	tne no hin 24 the Fu mplete	Med	only one) 3 Certifying Nurs	ner: On the basis of exa e Practioner: To the be		leath oc	curred at th	ne time, date ar		due to the	cause(s) ar	nd manner as	stated.	ner stated.
			29b. Signature and title of certifier	tsur			9c. Licens <i>DO</i>	e number 2059 4	87	2		igned (Month 2 - 29 -		
	ans		30. Name and address of person who c	ompleted cause of dea	,			-		21601			-	
	Stat Registra	te ar	31. Date filed (Month, Bay, Year)	32. Registrar's	Signature			IMAU I OI	. 1111	_1001				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ \mathbf{A}^{M} Mary Audrey McClaine 2010 7:40 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Berlin Nursing & Rehabilitation Center Berlin 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 □ M 2 🖾 F Months Days Hours (Month, Day, Yea Country)
Maryland 91 Yrs **Director** 222-03-2472 Usual Residence of Deceden or 28a-f show e notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 72 hours after death with the Maryland Director 1 X Yes 2 No MD Worcester Berlin ^{10e.} Street and Number Mid Atlantic Long Term Care 9715 Healthway Drive 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a o Funeral 21811 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced white Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 lath and Mental Hygiene.
27 is marked other than "r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) cosmetology Beautician McClai Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hv.
Important: If item 27 is markany injury or other. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ൧ Clarence James Calhoun Lillie Mae Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. McClaine (Son) 1216 1st Avenue W#202, Seattle, WA 98119-3548 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 🗵 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva Jan. 2, 2011 Delmar, Delaware Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home ewel Delmar, DE 13 East Grove Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Insertand Death Immediate Cause (Final Ph_sician/ days disease or condition *≱* Medical resulting in death) Examiner ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami ears that the death certificate be executed burial-transit and that initiated events resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗶 No Month Year Day 5 Other (specify) Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ tension 1 Yes 2 No 3 Probably 4 Yunknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Coronary 24a. Was an autopsy performed has 1 Yes 2 No Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Н 0070020 December 31, 2010 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) D.O Diane Ceruzzi 9715 Healthway Dr, Berlin, MD 21811

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Richard Maloof 11:20 AM 010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico 4701 Whitehaven Road Ouantico Sex 1 X M 2 D F . Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 579-50-4095 68 03/31/1942 Director Massachusetts Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Wicomico Quantico 1 Yes 2 X No Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4701 Whitehaven Road 21856 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Bace - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Army Year or Dates. Army 1 Yes 2X No Specify: Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) photographer photography Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy
Important: If item 27 is marked ott
any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Caroline Watson Daniel maloof 19a. Informant's Name/Relationship (Type, Print)

Joan maloof/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4701 Whitehaven Rd., Quantico, MD 21856 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Salisbury Crematory 12/29/2010 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Edineral Service Licens 22 Name and Address of Facility Holloway Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 🗌 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 No Other: 1 Yes Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manger of Death 28a. Date of injury (Month, Day, Year) 28h. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation Suicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Medical Registrar

nd title of certifier 31. Date filed (Month, Day State JAN 0 3 2011

Homicide

29a. Certifier (Check

only one

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Location (Street and Number or Rural Route Number, City or Town, State)

BOX 1733 Salky MD 21802

Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

Dester

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1-For Amend Items 29c,d per dr.,g9	partment of 1 2,02716/2 ertificate of 1	Health and I 011 dhb Death	Mental Hygi Re	ene g. No. 20 1 0	12962
	Physicia		1. Decedent's Name (First, Middle, Last) Dorothy J. Miller			2. Date of Death Month December	Day Year	3. Time of Death 10:20 a ^M
	Medic Examin		4a. Facility Name (if not institution, give street and number) Lakeside Assisted Living	4b. City, Town, o	r Location of Death		4c. County of Dea	ath
Mary .	Funeral		Lakeside Assisted Living 5. Social Security Number 6. Sex 1 □ M 2 ♣ F 84 Yrs		If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Bi	rthplace (State or Foreign
H	Director ≥		Usual Residence of Decedent			12/30/1	925 I.	llinois
	aryland a-f sho ified at	ector	10a. State 10b. County 10c. City, Town or Maryland Wicomico Salisbut					10d. Inside City Limits 1 ★ Yes 2 □ No
	a or 28 be noti	al Dir	10e. Street and Number Lakeside Assisted Living			10	Og. Citizen of What C	ountry?
	erth with erns 23 rmust	Funeral Director	11.09 S. Schumaker Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13	2].80 3. Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Am	erican Indian.
36	e filed within 72 hours after death with the Maryland Ital Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.	If Yes, specify Cuba		Rican, etc.)	Black, Whi	
2-0	72 hours "natur edical I	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Given	edent's Usual Occup	during most of worl	king 1	6b. Kind of Business	
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land	l be filed Iental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, Last) Frank Misek		18. Mother's Nan Charlot	ne (First, Middle, Ma te (1	aiden Surname) unknown)	
Maryland 21215-0036	1 and 2 should be file of Health and Mental I item 27 is marked o other traumatic eve		19a. Informant's Name/Relationship (Type, Print) Thomas Miller/son 19b. Ma 376	iling Address (Street O Devonsh	and Number or Rui	ral Route Number, C Salisbury	City or Town, State, Z	ijp Code))4
Baltimore,			1 Burial 2 Cremation 3 Removal from State cemetery, co	position (Name of rematory or other place y Cremator	i		Salisbury	
Baltii	permit. Page Department of Important: If any injury or once.							Association 804
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	Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	.VD				Original Death
		ner	Sequentially list conditions, If any, heading to immediate Due to (or as a consequence of the consequence o					
	icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last C. Due to (or as a consequence of):					
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. Bo	he death y the atti iched for	Physician/M		Other (specify)			Month	Day Year
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Rec	sician: The law i certificate has t irector, page 2 s		25. Was case referred to medical			perform 1 \square Yes 2	ed? death?	
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n of	iding Ph th. : After th : funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time injury (Month, Day, Year)	work	y at <br Yes 2	28d. Describe how	v injury occurred	
Division of Vital Records, P.O. Box 68	Il or Atter after dea Director d in by the	Certificate:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	treet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1	estigation, in my opinie	on, death occurred a	at the time, date and	place, and due to the	cause(s) and manner stated.
	70 th within 70 th	~	29b. Signature and title of certifier	29c. License D470	e number	29	d. Date signed (Mon ebruary 5	th, Day, Year)
	CM		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	116(UN S	heer s	AUISBUR	1 MD 21804
	Stat Registra		30. Name and address of person who completed cause of death (Item 23a) (Type VII VATERAV 14 31. Date filed (Month, Day, Year) 7 2010 32. Jegistrar's Signature 1	back	/	, , ,		

Please Type or Print in Black Indelible Into Epsura All Copies Are/19gible.

Amend Item 26 per med cert of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charles Eugene Mowen, Sr. 2010 12:16 AM December Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Washington 20532 Trovinger Mill Road Hagerstown Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 ₩ 2 □ F Months Hours May 19, 1926 Mary Tand Director 220-18-0444 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f sho miner must be notified at Director 1 Yes 2 X No Washington Hagerstown Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 U.S.A 20532 Trovinger Mill Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Medical Examiner Anmed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify. White 43 - 453 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Post Master Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ethel Provard Daniel Herman Mowen 19a. Informant's Name/Relationship (Type, Print)
Mary A. Mowen (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20532 Trovinger Mill Rd. Hagerstown, Md. 21742 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan. Smithsburg, Md. Smithsburg Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. M01414 WIS 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 12B1112170124 Hy disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine cause (Disease or linjury the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day 2 No 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COROLARS ARTERY 1 Yes 2 No 3 Probably 4 Unknown PROTEINULED 24b. Were autopsy findings available prior to completion of cause of • Hospital or Attending Physician: The law 24 hours after death.
• Funeral Director: After this certificate has autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: ည 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 1-3-2=11 0-12313 10. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Eli Roza, MD 12931 Oak Hill Avenue, Hagerstown MD 21742 30. Name and address of person wi

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM# 25 per ME, G915, 5/2 3/2011, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2010 () AULO ECEMBER NORCROSS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year HOSPITAL PITAL CENT.

Age (In yrs. last birthday) HESTER ar If Under 24 Hrs. ys Hours Min. HESTER R OWN 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days 1**X** M 2□ F Director 194-36-8003 63 03/08/1947 **PENNSYLVANIA** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 XNo Director CHESTERTOWN KENT MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 21620 21217 TEXAS AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore. Maryland 21215-0036 1 □Yes 2 X No þ Specify. 3 ☐ Widowed 4 ₺ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RESTAURANT OWNER/OPERATOR RESTAURANT 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANNA BETTY WHITE ပ္ EDWIN BRUZAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21326 HAVEN ROAD ROCK HALL, MARYLAND 21661 TRISHA JACOBS 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State injury or CHESTER, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 12/30/2010 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME,
130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CVD 5 disease or condition resulting in death) Junely Ruitwell, WAS for D. T. FUS CERTIFICATION APPROVED BY MEDICAL EXAMINER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence off sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.0. as been signed by the 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 Probably 4 → Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed' certificate 1 ☐ Yes 2 ☑ No 2 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours a Hospital 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 21620

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink Ensure All Conjest Argules Argules Provided State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RICHARD Month 21:05 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MERITUS MEDICAL CENTER HAGERSTOWN WASHINGTON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 ☐ M 2 ☐ F Months Days Hours Min. (Month, Day, Year) Director 39 233-19-1345 /28/1971 WEST VIRGINIA Usual Residence of Decedent 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f sl Examiner must be notified 1 Yes 2 No WASHINGTON HAGERSTOWN MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 16923 SHINHAM ROAD USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc þ 1 X Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: WHITE Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) MANUFACTURER QUALITY CONTROL INSPECTOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LAWRENCE NOLL VICKIE MORRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 159 BELVIEW AVE., HAGERSTOWN, MD 21742 VICKIE L. MARSCHNER/MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Donation 5 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) DEC. 22, MARTINSBURG, WV ROSEDALE CEMETERY 2010 21. Signature of Funeral Service Licensee BROWN FUNERAL HOME, PO BOX 821, MARTINSBURG, WV 25402 KING ST. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ 14/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examine Due to (or as a consequence of) attending physician and for use as the bunial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day 2 No 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Hospital or Attending Physician: The I 24 hours after death.
 Funeral Director: After this certificate h 2 No Yes 2 X No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 ื Natural 28b. Time of 28a. Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) work?
1 Yes 2 No 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death place, and due to the cause(s) and manner stated.
3 Ceriffying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number D0065024 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) East Antietam St., Hagerstown MD 21740 LONIQUE 251 60 31. Date filed (Month, Day) (e State Registrar

Jeanne Panker

			Plea	ase Type or Pri					-		_	
			For State Registrar	State of M	arylan		partment of l ertificate of l		Mental Hy	giene Reg. No	21111	12966
	Physicia Medic		1. Decedent's Name (First, Middle Jeanne Carlson	,					2. Date of De Decemb		30, 2010	3. Time of Death 4:30 P M
-4	Examir	er	4a. Facility Name (if not institution Heartfields A		ng		4b. City, Town, o	r Location of Deati	1	P ^{4c}	c. County of Deat rince Ge	e <mark>orges</mark>
	Funeral Director		5. Social Security Number 252-34-0928	6. Sex 7. Ag	e (In yrs. la 86	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da June 4			hplace (State or Foreign untry) YOCK
	yland -f show ed at	ctor	Usual Residence of Decedent 10a, State 10b. County			y, Town or L	ocation					10d. Inside City Limits
	n the Ma a or 28a be notifi	al Director	Maryland Prin 10e. Street and Number	ce Georges	Lar	nham _	10f. Zip Code			_	itizen of What Co	1 ☐ Yes 2 🛣 No untry?
	eath wit tems 23 er must	Funeral	9217 Morley Ro	12, Was Decedent I	Ever in U.S	S. 13.	20706 Was Decedent of H	ispanic Origin? (Sp	pecify Yes or No-	USA	14. Race - Amer	rican Indian,
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	b	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	16 1/2 - 01	. No		If Yes, specify Cuba 1 ☐ Yes 2 🕅 No		o Rican, etc.)		Black, White Specify: Wh	e, etc.
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Baltimore, Maryland 21215-0036	d 2 shoul alth and I n 27 is ma er trauma	1	19a. Informant's Name/Relations Robert S. Park	, , , , , , , , , , , , , , , , , , , ,		1	ling Address (Street				r Town, State, Zip	Code)
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~-[h sician/ Medical	0.0	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on each line O a.	erdi	o vasc	ular A	therose	leso hi	e di	Searce	Approximate Interval Between Onset and Death ON YEAVS
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	uted Id ansit	Examiner	if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	Due to (or as a	a consequ	ence oi).						
0	e be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a	a consequ	ence of):		***				
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live Birth 4 □ Pregnant a 9 □ Unknown	2 Feta	death 3	☐ Ectopic pregnand	Sy .			23d. Date of deli Month	ivery Day Year
P.O.	s that the gned by t e detach	by Phy	Part II. Other significant condition	ns contributing to death b	ut not res	ulting in the	underlying cause giv	ven in Part I.	23e. Did to	obacco u	use contribute to	the cause of death?
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on of	Attending Phy r death. ctor: After this y the funeral o	cate: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir 2 ☐ Accident Investi	28a. Date of injuring (Month, Day	ry	28b. Time of injury	work	/ at	28d. Describe h		Other (Speci y occurred	<i>ty)</i>
Jivisio	al or Atte s after dea I Director d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be	iry - At ho :. (Specify)	me, farm, st	reet, factory, office		28f. Location (S City or Tow		d Number or Run)	al Route Number,
_	ne Hospitz n 24 hours ne Funeral pleted fille	Medical	(Check 2 Medical E	Physician: To the best of examiner: On the basis of ex	my knowle xamination	edge, death and/or inve	occured at the time stigation, in my opinio	date and place, a on, death occurred a	nd due to the ca at the time, date a	use(s) ar ind place	nd manner as state, and due to the c	ted. ause(s) and manner stated.
	To the withing the company of the co		29b. Signature and title of certifier	Jambera	MI	٥,	29c. License	number 5 8 0	213	29d. Dat	te signed (Month,	, Day, Year)
0	1410.		30. Name and address of person of FARUAU TAMALI	who completed cause of de MD 12150	eath litem	23a) (Type,	eccured at the time stigation, in my opinion destination or the stigation of the stigation	6 leun	Dale	e al	0 207	769
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Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

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		State Registrar					tificate of L			Reg. No	10 42	967
Physicia Medic	al	1. Decedent's Name	É	FAR	KER		T		2. Date of Dea Month	2×7	2010 2	e of Death
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Funeral Director		5. Social Security Nu 578–38–80 Usual Residence of	629	Sex 1 M 2 F	7. Age (In yrs. Ii 88	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H		h (Year) 1922	9. Birthplace (Sta Country) Kentucky	te or Foreign
Aaryland 8a-f show tified at	Director	10a. State	10b. County	George's		y, Town or Lo	cation					e City Limits
s 23a or 2 ust be no	Funeral Di	10e. Street and Num		t.			10f. Zip Code 2071	6		10g. Citizen of USA	What Country?	
permit. Fage 1 and 2 should be lined within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Marrie 3 ☑ Widowed 4		Armed For	2 🔀 No	'	Was Decedent of H f Yes, specify Cuba □ Yes 2 🖾 No	n, Mexican, Pue	Specify Yes or No- erto Rican, etc.)		ce - American Indian ck, White, etc.	,
vithin 72 hou jiene. er than "nati the Medica	Completed	(Spec	15. Decedent's cify only highest g anday (0-12)		4 or 5+)	(Give life. D	lent's Usual Occup kind of work done o O NOT use retired) nemaker		orking		Home	
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Depar Impor any in		21. Signature of Fun	eral Service Lice	nsee			Name and Addres		Beall Fu v., Bow	neral H vie, MD	iome 20715	
hysician/		Immediate Cause (F disease or condition	t failure. List only Final	pications that ca	aused the death th line.				ac or respiratory arro		Approxii Interval On a	mate Between nd Death
Medical Examiner		resulting in death)	ſ	■ Due to (d	or as a consequ	ience of):	6 ner	tens	nos	U	y.e.	n
nd transit	Examiner	Sequentially list con if any, leading to importance. Enter Underly Cause (Disease or li that initiated events	mediate lying injury	c	or as a consequ		//					
ician	ख्र	resulting in death) La	ast	Due to (c	or as a consequ	ience of):						
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the		IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 9 Unknown	nonths?		Birth 2 ☐ Feta ant at time of d	Ideath 3	Ectopic pregnanc Other (specify)	у			ite of delivery onth Day	Year
an signed build be deta	<u>م</u> ا	Part II. Other signific	cant conditions	contributing to de	ath but not resi	ulting in the u	nderlying cause giv	en in Part I.			ribute to the cause of 3 Probably 4	
ate has bee	Completed								24a. Was a autop: perfor 1 Yes	sy (Were autopsy finding prior to completion of death? 1 Yes 2 No	
certific irector,	a B	25. Was case referred examiner? 1 Yes 2		Hospital:			Othe	ace of Death (Ch				
ath. r: After this e funeral d	Certificate: To	27. Manner of Death 1 Natural 2 Accident	5 Pending	28a. Date o (Month	npatient 2 f injury n, Day, Year)	ER/Outpatien 28b. Time of injury	28c. Injury work	4 ∐ Nursing at	Home 5 ☐ Reside 28d. Describe ho			
is after desail Director		3 Suicide 4 Homicide	6 Could not determined	be 28e. Place of	of Injury - At hor g, etc. (Specify)		et, factory, office		28f. Location (St City or Town		er or Rural Route Nu	mber,
thin 24 houther the Funer	Medical	(Check 2 L only one) 3 [Medical Exan Certifying Nu 	niner: On the basis	of examination	and/or invest	gation, in my opinio eath occurred at the	n, death occurred time, date and p	place, and due to the	nd place, and due cause(s) and ma	e to the cause(s) and anner as stated.	manner stated.
. ₩ . 00		29b. Signature and ti	al	No.	2W	ta w	29c. License	1143	5		Month, Day, Year) whith	10/0
101		30. Name and addres	tel J.	Late	NW	m	YYTDE	FE NST	Hwy A	NNAPO	Mon	1401
State Registra	~	31. Date filed (Month,	JAN 03	2011 32. Re	strar's Signati	A. A	back		/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Richard Joseph Parks Physician/ December 30, 2010 5:20 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 503 Doris Avenue Anne Arundel Baltimore Social Security Number 7. Age (In yrs. last birthday) 77 Yrs. 8. Date of Birth
(Month, Day, Year)
Nov. 30, 1933 If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 217-30-3040 Months 1 🛛 M 2 🗆 F Hours Director Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Anne Arundel Baltimore Maryland 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 503 Doris Avenue 21225 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces' Black, White, etc. þ 1 Never Married 2 XX arried 1 X Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates. 1953-57 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Lineman/Instructor Electric Company of Health and Mental Hygie If item 27 is marked other in other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Charles Lincoln Parks Teresa Dorothy Cain t. Page 1 and 2 should by treent of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print)
Yvonne Parks/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 503 Doris Avenue Baltimore, Maryland 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or conce. 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 1/5/2011 Crownsville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility John M. Taylor Funeral Home 07 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final ERE BROVA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ng physician and as the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Box 68760 IF FEMALE use 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown 9 Unknown detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be def 23e. Did tobacco use contribute to the cause of death? Completed by YELLIMUS 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy HEMIPARES performed? Yes 2 No death? completed filled in by the funeral director, Be 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဂ 1 Inpatient 2 ER/Outpatient 3 DOA ne Hospital or Attending Pl n 24 hours after death. e Funeral Director: After th 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 🛈 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 3 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DOD02519 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRAIN OWERS +ISHEIZ KICHARD

Registrar

State

31. Date filed (Month

32. Registrar's Signature

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dale Parker 30 2010 December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death iomil Marlial Cente 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Delaware **Funeral** 1 XM 2 Months Days Hours Min. (Month, Day, Year) 01/02/1936 222-24-2098 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Florida Volusia Ormond Beach 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 32174 USA 314 Creek Lane within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) truck driver transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Samuel Parker Lyda Wooten 19a. Informant's Name/Relationship (Type, Print)
Doris Parker-Brown/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 523 McIntosh Rd., Ormond Beach, FL 32174 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Volusia Memorial
Park 1 X Burial 2 Cremation 3 Removal from State 01/07/2011 Ormond Beach, FL 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign turn of Funeral Service Licensee HOTTOWAY SPOTERS 501 Snow Hill Home Professional Association Rd., Openbaro Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCUD Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Completed by Physician/Medical Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2: autopsy performed? Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No 1 Inpatient 2 K ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title 29d. Date signed (Month, Day, Year) 1/3/2011

Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ODE Carroll

yder JAN05 St

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charles Purnell 0335 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NICOMIC ional Markal cente Year If Under 24 Hrs. 8. Pate of Birth 6-25-1946 9. Birthplace (State or Foreign MD^{Country)} **Funeral** 1 📉M 2 🗆 F Months Days Hours Min 217-42-6132 Director Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Newark 1 Yes 2 X No Worcester MD 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 21841 7649 Patey Wood Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 10 þ 1 Never Married 2X Married 72 hours after Maryland 21215-0036 1 Yes 2X No Specify. "natural", ^{Sp}BYack Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Gillis Cement Finisher Gilkerson Const ermit. Page 1 and 2 should be filed wi epartment of Heath and Mental Hygic nportant: If item 27 is marked other y injury or other traumatic event. th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Glendola Holland Charles Purnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7649 Patey Wood Rd, Newark, MD 21841 Pamela Purnell/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, 1-3-2011 Hurlock, MD Veteran's Cem 22. Name and Address of Facility 917 W. Isabella St. Funeral Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Neu Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 I Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No Yes 2 1 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: 뎯 Other: 2 🗆 🖬 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28c. Injury at 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ss of person who completed cause of death (Item 23a) (Type, Print) ST. 31. Date filed (Month And), Year 201 Registrar's Signatur Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 Day Year 11:50 PM Irene M. Phillips 0105 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Salis at the Oastal Ho bur icamico If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Hours Min. (Month, Day, Ye Maryland **Director** 83 218-20-9769 Aug. Usual Residence of Decedent Department of Health and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item Z1 is marked other than "natural", or items 23a or 28a-f show once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Nanticoke Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21840 U.S.A. 20349 Nanticoke Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give white 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) accounting 12 secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bertha Banks Harry Lee Messick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20349 Nanticoke Drive Nanticoke, MD Julian Phillips (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Delmar, Delaware 4 Donation 5 Other (Specify) Crematory of Delmarva Jan. 3, 2011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Short Funeral Home Delmar, DE 13 East Grove Street UI. 23a. Part 1. Enter in disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ MA4GUANT disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 ponths? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe After this certificate 2 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier D00584110

State Registrar DHMH 17 Rev 7/2009 6 Huin

Date filed (Monti

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SANSBURY

2/802

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dec 29, 2010 1:02 A Dorothy Louise Rinkes Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Feb 26. 1944 Virginia **Director** 213 40 3018 66 Usual Residence of Decedent 28a-f shov or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XXVo Maryland Calvert Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 32 Paulowinia Lane 20678 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc ρ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, GiveXX Year or Dates. Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify. 3√√√ Widowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Agent Insurance æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ge 1 and 2 should be filed nt of Health and Mental H t: If item 27 is marked ot Robert A. Weatherington Louise E. Horton any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Rinkes (Son) 32 Paulowinia Lane, Prince Frederick, MD 20678 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Page 1 g permit. Page 1 and Department of I 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington National Cemetery Jan 5, 2011 Suitland, Maryland 21. Sign ture of Funeral Service License 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) neumoni Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or line) Due to (or as a consequence of): physician and s the burial-transit Exami or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s this certificate has autopsy performed? death? 2 🗌 No 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of s after death. Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occured at the time, date and due to the cause(s) and manner stated.
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

Registrar DHMH 17 Rev 7/2009

State

3 E

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) JAN03

Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 8:15p M Dec. Daniel A. Richmond Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 118 Hollingsworth Manor 5 Cecil E1kton Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 57 A 8 Date of Birth **Funeral** Months Days Hours Min Year 945 1 □XM 2 □ F May 26, 65 Yrs VA **Director** 213-46-5960 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Cecil E1kton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 118 Hollingsworth Manor 5 21921 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🗰 No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced r than "natura the Medical E Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the In Construction Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ George W. Richmond Mildred Mitchem 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 118 Hollingsworth Manor 5 Elkton, MD 21921 Crystal Truitt/ daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Union Church Cemetery 1/3/2011 4 Donation 5 Other (Specify) Elkton, MD Name and Address of Facility LI. Foard Funeral Home 59 E. Main St. Elkton, 21. Signature of Funeral Se ₹.\\ 259 Home, E. 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the huneral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ■ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Yes 2 R 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

Division of Vital Records, P.O. Box 68760

State Registrar 29a. Certifier

29b. Signature and title of certifie

MohammadAf

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

DHMH 17 Rev 7/2009

39 W. Main (

82. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

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State Registrar

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ROBERT B. SANCHEZ, MD 508 IDLEWILD AVE., EASTON, MD 21601

31. Date filed (Month, Day, Year)

JAN 0 3 2011

32 Registrar's Signature

A Ave., EASTON, MD 21601 DHMH 17 Rev 7/2009

		_	For State	State of Ma		d / Depa	artme		h and M	_	giene	211	0	42975
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	Funeral Director		Social Security Number 6. Se			Yrs.	If Und Month		der 24 Hrs. rs Min.	8. Date of Bir (Month, Da 10/15/	th 17, Year) 1952		9. Birthp Count	lace (State or Foreign ry) PA
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Baltimore,	permit. Page 1 and 2 si Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	20b. P	lace of Dispo emetery crer DLAWN PARK	natory of	ame of other place) RLAL	01/04)ate /2011		ocation -	City or To	wn, State
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Division of Vital Records,	: The law req cate has bee ; page 2 shor	Completed by								24a. Was auto perfe 1 \sum Yes	psy ormed?	, ,		osy findings available mpletion of cause of
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_	3		30. Name and address of person who co Gwen Lacerda, MD, 22 S. Greenes	ompleted cause of de University Street, Bo	eath (Item	23a) (Type, F harylar	Print) M	edical cer	nter; Di	epartur	rent	of.	Media	time
	Stat Registra	e ar	31. Date filed (Month, Day, Year) DEC 2 9 2010	32. Registra	rs Signat	ure fav	Kal	•						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Ronald Preston Roberts DYCEMBER Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death MARYLAND HEALTH CARE SYSTEM PEARY POINI **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Nov. 20, 1935 9. Birthplace (State or Foreign 1 **X**□ M 2 □ F Months Days Hours Director 295-30-9393 75 Country) Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits must be notified 28a-f Maryland Harford Bel Air 1 🗆 Yes 2 🙀 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ral", or items 23a Examiner must be 1203 Glastanbury Way 21014 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give IR NOWN TO PHYSICIAN: Black, White, etc. ş 1 Never Married 2 Married altimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2 X No Specify: Completed 3 Divorced Year or Dates White other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) unknown Elementary/Seconday (0-12) unknown Barber unknown Be Important: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Roberts Gladys Upchurch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Addicks 1203 Glastanbury Way, Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 206. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Garrison Forest 01/12/11 4 ☐ Donation 5 ☐ Other (Specify) emetery Marvland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 Shomes m.t. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Known Securitially list our littlere. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician the burial Physician/Medical Records, P.O. Box 68760 as attending IF FEMALE: ise s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month 5 Other (specify) Day Year the a 1 ☐ Yes 2 ☐ Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖟 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an within 24 hours after death.

To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 autopsy performed? 2 No 1 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔏 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🐧 Natural 5 Pending work? Accident 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the I only one Certifying Nurse Practioner: To the best of manner as stated 29b. Signature and title of certifie 29c. License number 7 & 3 29d. Date signed (Month, Day, Year) Name and address of person w 23a) (Type, PTR) NEALTH CARE SYSTEM, KARITHANOM M.J. IVA 32. Registrar State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2 Wendell Holmes Rhodes 2010 9:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death (COASTAL HOSPICE AT LAKE) SALISBURY WICOMIC **Funeral** 5. Social Security Number **221–14–1153** 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 86 Director 0872871924 VPrginia Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Wicomico Salisbury 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21801 USA 300 Lemmon Hill Lane, Room 34 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify: "natural", white 3 Widowed 4 Divorced Army Specify: Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) WENDELL College (1-4 or 5+) Bus Driver Bus Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Minnie Catherine Bonawell Page 1 and 2 should be Norrie Thomas Rhodes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
120 Sandy Hill Rd., Cambridge, MD 21613 Sandra Potter/daughter Rhodes 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place Springhill Memory Gardens Burial 2 Cremation 3 Removal from State any injury or onation 5 🗆 Other (Specify) 01/03/2011 Hebron, MD 21 Rolloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 roccyrrox aure 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? After this certificate 1 Yes Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c, Injury at 28d. Describe how injury occurred Natural 5 Pending Accident
Sulcide Investigation 1 Yes 2 No after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide Location (Street and Number or Rural Route Number, determined City or Town, State within 24 hours a To the Funeral C Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year)

State Registrar 910

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician:

Examiner and burial-tra attending physician the as asn for signed by the a has certificate Be Certification: To After n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral pletely filled in Medical the

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examine

Physician/Medical

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Completed

MD

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Extrainer must be modified at once.

Physician

/Medical

Baltimore, Maryland 21215-0036

			1 □ Yes 2 □	No 3☐ Probably Unknown			
			24a. Was an autopsy performed? 1 □Yes ♠No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No			
25. Was case referred to medical examiner?		26. Place of Death ((Check only one)				
1 Ves ZX	Hospital: 1 ☐ Inpatient 2 ☐ EB/Outpatient 3[spital: 1 Inpatient Impatient Inpatient Impatient Impati					
27. Manner of Death Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		28c. Injury at Work?	d. Describe how injury				
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office 28	f. Location (Street and City or Town, State)	Number or Rural Route Number,			
29a. Certifier Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of my knowledge, death occuniner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, an ation, in my opinion, death occurred	nd due to the cause(s) a d at the time, date and p	and manner as stated. place, and due to the cause(s)			
29b. Signature and title of certifier		29c. License number	29d. Date	signed (Month, Day, Year)			
1/20		D0065385	12	, 26, 2010			

death.

State Registrar

Dr. Alex Rosin

11711 Livingston Road Fort Washington, MD 20744-5164 31. Date filed (Month, Day, Year) 32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12/28 2010 Year Nicholas Lawrence Soldo 2:58 рм Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Frederick Calvert Calvert Memorial Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 NV **Funeral** 1 X M 2 D F Days 114-22-1720 0476671933 Director NY Usual Residence of Decedent 23a or 28a-f show perriit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Der artment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Dunkirk 1 ☐ Yes 2 🕅 No MD Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20754 U.S.A. 3011 Drury Lane 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces?
XYes 2 No
Yes, Give Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Assistant Director of Statistal FAA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lillian Scalingi Lawrence Nicholas Soldo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucille Soldo/Wife 3011 Drury Lane, Dunkirk, MD 20754 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Crematory 12/30/2010 Clinton, MD 21. Signature of Foreral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Md Blvd., Owings, MD 20736 Lisa M. Mounts 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARRYTHMIA disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exam Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death g Unknown ed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: 1 Inpatient 2 Certificate: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending 24 hours after death. Funeral Director: A Investigation Could not be Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed within 2 To the I 3 Certifying Nurse Practioner/To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lov

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

0n1

32. Registrar Signature

oital Road

			For State Registrar	ate of Maryland / D	Department of H Certificate of D		, ,	m m 1 A	40020
			Decedent's Name (First, Middle, Last)		00/11/10410 0	, cati.	2. Date of Dea		3. Time of Death
	Physicia Medic		Margaret Ellen Scha	ffer			December	r 29, 2010	8:30 P M
	Examir		4a. Facility Name (if not institution, give street	,	4b. City, Town, or			4c. County of Death	
	<u> </u>		3856 Shadywood Drive 5. Social Security Number 6. Sex		Jeffers			Frederic	
l	Funeral Director		219-22-4899 Usual Residence of Decedent	7. Age (In yrs. last birth	yrs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day, April 2	g. Birth 21,1929 Mary	nplace (State o <i>r Forei</i> gn ntry) Y Land
	and show	ē	10a. State 10b. County	10c. City, Town					10d. Inside City Limits
	Maryl 28a-f otified	Funeral Director	Maryland Frederick	Jeffe:	rson				1 🗆 Yes 2 🏪 No
	a or 2	Ö	10e. Street and Number		10f. Zip Code			10g. Citizen of What Cou	intry?
	th with ms 23 must	ner	3856 Shadywood Drive		21755			United Stat	tes
Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at.	ρ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced 12. W Alt 1 1 1f Ye	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.			
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lan	should I and Me is marl raumati	3	19a. Informant's Name/Relationship (Type, Pri	7	Mailing Address (Street ar	nd Number or Rura	l Route Number,	City or Town, State, Zip	Code)
≥,	and 2 Health tem 27		Linda Chipley/Daught		856 Shadywoo	d Drive,	Unit 2-	-D Jefferson	n, MD 21755
ore	ge 1 a it of H if ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo	/al from State cemetery	Disposition (Name of , crematory or other place	e) <u>i</u>		20c. Location - City or T	
Itim	it. Pagintmer intant injury		4 ☐ Donation 5 ☐ Other (Specify)	Resthar	ven Cremator	7 1 1 1		Frederick,	
Ba	permit. Page 1 and : Department of Healt Important: If item 2 any injury or other		21. Signature of Funeral Service Licenses		19501 Catoc	tin Moun	tain Hwy	s, Skkot Cod . Frederick	ly P.A. , MD 21701
			23a. Part 1. Enter the disease, or cor plicatio shock, or heart failure. List only one cau	s that caused the death. Do no e on each line.	t enter the mode of dying,	, such as cardiac o	r respiratory arre	st,	Approximate Interval Between
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09	cate be executed physician and s the bunal-transi	edical Examiner	d						
387			IF FEMALE;						
Division of Vital Records, P.O. Box 68760	or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the bunal-transit.	Physician/N	in the past 12 moviths?	res, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death ☐ Pregnant at time of death	3 Ectopic pregnancy			23d. Date of deliv	ery Day Year
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Ö	iw req	Completed					24a. Was ar		psy findings available
Rec	The law cate has page 2 t	팅					autops perform 1 \(\sum \) Yes 2	ned? death?	mpletion of cause of
ta	sician: The certificate rector, pag		25. Was case referred to medical examiner?			ce of Death (Check		Z NO 1 Les	2 🗆 110
>	Physic this c	욘	1 Yes 2 No Hospita	1 Inpatient 2 ER/Outp		4 ☐ Nursing Ho	me 5 Reside	nce 6 Other (Specify)
0	al or Attending P s after death. I Director: After t d in by the funera	Certificate:	1 Natural 5 ☐ Pending	t. Date of injury 28b. Tin (Month, Day, Year) inju	ury work?		28d. Describe how	w injury occurred	
Sio	Atten deat ctor: y the	ij.	2 Accident Investigation 3 Suicide 6 Could not be	. Place of Injury - At home, farm		es 2 No	20f Lanation /Car	not and Alimbara a Direct	Davida Alexandra
<u> </u>	al or / s after I Dire		4 Homicide determined	building, etc. (Specify)	i, street, factory, office		City or Town,	eet and Number or Rural State)	Houte Number,
_	To the Hospital or A within 24 hours after To the Funeral Directory completed filled in b	Medical	(Uneck 2 Medical Examiner: On	o the best of my knowledge, de the basis of examination and/or i	investigation, in my opinion.	death occurred at	the time date and	I place and due to the car	rea/e) and manner etated
:	vithin or the		only one) 3 L Certifying Nurse Pract 29b. Signature and title of certifier \(\chi \)	ioner: To the best of my knowled	dge, death occurred at the t	time, date and place	e, and due to the o	cause(s) and manner as st dd. Date signed (Month, i	ated.
	F > F 0		by his I	satas		1056890		12/30/2011	
		-	30. Name and address of person who complete	ed sause of death (Item 23a) (Tv					
	6		Caroline	(rossect	(a)0 9	h Are	nue	15 cunswich	5, MD 21716
	State Registra	~	JAN 4 201	32. Registrar's Signature	back!				
	negistra		7.20	· Jones Jo					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 115&18 Per FH G911 1/28/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Slider John R Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany WMHS-RMC Cumberland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD **Funeral** 8. Date of Birth Months Days Hours Min. Jul 5, 1945 Director 217-42-6510 65 Usual Residence of Decedent at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified MD Allegany 28a-f Cumberland 1 XYes 2 No 10e. Street and Number 'n 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a 16107 Misty Lane 21502 USA be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", 3 Divorced Specify white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) Benchmark Mech. Cont. President 7+ Be 17. Father's Name (First, Middle, Last) 18. NG 19 S Na Par First, Middle, Maiden Surname) ည John R. Slider Collen (Largent) Slider 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 16107 Misty Lane Cumberland MD 21502 Jennifer Slider wife 16107 Misty Lane 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or ot 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Restlawn Memorial Gardens 12/30/2010 LaVale MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign rure Funeral Service Licenses 22. Name an Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician arcihuma etaspho Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any leading to immedicause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 inding physician ause as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autonsy this certificate 1 🗆 Yes 2 🗖 No 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🗆 Other: ပ္ ER/Outpatient 3 DOA 1 Thipatient 2 🗆 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at After 28d. Describe how injury occurred □ Natural 5 Pending 24 hours after death. 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of dertifie 29c. License number 29d. Date signed (Month, Day, Year) 10 27,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 788 YA PO IAMC 9 31. Date filed (Month) Day Year State Registrar's Signature Registrar acke

VOID

CERTIFICATE

2010-42982

SEE

CERTIFICATE #

2010-42984

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Vaar Raymond Larry Spriggs, Sr. 5:16 P M Medical 2010 December 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 14 N. Chase Street Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 1 X M 2 🗆 F Months Days Country **Director** 219-46-0412 64 Yrs 11/18/1946 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD Allegany 1 X Yes 2 □ No Cumberland 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 14 N. Chase Street 21502 USA death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces?

1 X Yes 2 No 1964—
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify Completed 1965 Year or Dates Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Safety Engineer Tire and Rubber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ೨ Ralph Upton Spriggs, Sr. Washington Alistine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 N. Chase Street, Cumberland, MD 21502 Freida R. Spriggs / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Cumberland Crematory 01/04/2011 4 Donation 5 Other (Specify) Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, alure of Funeral Service Licensee 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Janares and disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. From 1 deriving Cause (Disease or linjury Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month 1 Yes 2 L 9 Unknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No မ 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iours after death.

neral Director: Affilled in by the full 1 Yes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1 XX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

State Registrar

nos

29b. Signature and title of certifier

JAN ()

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jesus H. Tan, M.D.,

Registrar's Signature

29c. License number

4 Broadway Street, Frostburg, MD

D21244

29d. Date signed (Month, Day, Year)

January 3, 2011

			1 - For State Registrar	State of M	iaryiand	•	irtment of F <i>tificate of E</i>				
			Decedent's Name (First, Midd)	le, Last)		001	imouto or E	Joann	2. Date of Deat		3. Time of Death
٠,	Physicia Medi		Leonard Verno	n Schlotzhau	er				12 ^{Month}	28 20	Î0 8:50p M
	Examir	ner	4a. Facility Name (if not institutio	n, give street and number)				Location of Death		4c. County of D	eath
-			Union Hospital 5. Social Security Number	6. Sex 7. Ao	je (1n yrs. lasi	t hirthchul	E1kton If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Cecil	Diabeter (Otate or Francisco
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ary	should and N is ma auma		19a. Informant's Name/Relations	ship (Type, Print)				and Number or Rura			Zip Code)
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Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra once.	ki'	20a. Method of Disposition 1 A Burial 2 Cremation 4 Donation 5 D Other		cen	netery, crem	sition (Name of atory or other plac of Lima	e) 1/3/		20c. Location - City Chesapeal	or Town, State ke City, MD
Ball	permit Depart Impor any in		21. Signature of Funeral Service	Licensee		R ²² .	Name and Address T. Foard 9 E. Mai	s of Facility Funeral n St. Elk	Home, P.	A 2 1 921	
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DHMH 17 Rev 7/2009

			For AMEND#29d per PHY State of Mai	ryland / Depa			ental Hygie	ne	
			= State Registrar 1/4/2011 AACO HEALTH DEPT C 1. Decedent's Name (First, Middle, Last)	MH Cer	tificate of De			No.2 1 1	12985
	Physicia		Thomas R. Schaefer				Date of Death Month	25, 2010	3. Time of Death
. €	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L		ecember	25, 2010 4c. County of Death	12:29 P ^M
-		•	Anne Arundel Medical Cente	r	Annapol			Anne Ar	
	Funeral		1 V M 2 D E	In yrs. last birthday) 65 yrs	If Under 1 Year		. Date of Birth	9. Birth	nplace (State or Foreign ntry)
	Director		397–42–6190 Vaual Residence of Decedent	05 Yrs.			(Month, Day, Yea ept. 12,	1945 Wis	consin
	and show dat	ro	10a. State 10b. County	10c. City, Town or Loc					10d. Inside City Limits
	Maryl 28a-f otifie	Director	MD Anne Arundel	Annapol	lis				1 🗌 Yes 2 🎇 No
	h the Saor		10e. Street and Number 1222 Ramblewood Drive		10f. Zip Code		10g	. Citizen of What Cou	intry?
	e filed within 72 hours after death with the Maryland tal Hygiene. And Hygiene. And cother than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral			21409			USA	
(0	or ite	by Fu	11. Marital Status 1 □ Never Married 2 ☒ Married 12. Was Decedent Eventher Forces? 1 □ Yes 2 ☒ Norried	lf.	Vas Decedent of Hisp Yes, specify Cuban,	Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - Ameri Black, White,	
93	rs afti ıral", Exar		3 Widowed 4 Divorced If Yes, Give Year or Dates.	1	☐ Yes 2 💢 No	Specify:		Specify: Wh	ite
21215-0036	2 hou "natu	Completed	15. Decedent's Education (Specify only highest grade completed)		lent's Usual Occupati		168	o. Kind of Business Ir	ndustry
121	ene. than the M	Som	Elementary/Seconday (0-12) College (1-4 or 5+)		NOT use retired)			Automotic	
d 2	filed within al Hygiene. d other tha vent, the N	Be	17. Father's Name (First, Middle, Last)	1 50		8. Mother's Name (F	irst, Middle, Maio	Automoti [*] den Surname)	ve
Maryland	12 should be file lith and Mental I 27 is marked o r traumatic eve	욘	Frederick Schaefer			Jean Rei	miker	,	
lan,	shoul and I is ma		19a. Informant's Name/Relationship (Type, Print)		g Address (Street and		oute Number, City	y or Town, State, Zip	Code)
	1 and 2: of Health item 27		Priscilla Schaefer / Wife		2 Ramblewo			lis, MD 2	
Baltimore,	Page 1 nent of I ant: If its ary or of		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State		natory or other place)	Decemb	er 27	c. Location - City or T	·
ij	교육원들		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euseral Service Licensee	Metro Cre				altimore,	
ñ	permi Depar Impo any ir			Ba	rranco & 1 5 Ritchie	Sons, P.A Hwv.	 Severn 	a Park Fu a Park. M	neral Home
			23a. Part 1. Soter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.						Approximate Interval Between
-1	hysician/		Immediate Cause (Final disease or condition	tastati	e Lu	ис Св	neer		Onset and Death
	Medical Examiner		resulting in death) Due to (or as a co	onsequence of):		5			
		je.	Sequentially list conditions, if any, leading to immediate Due to (or as a c	onsequence of):					
	uted d ansit	Examine	Cause (Disease or iinjury						
	cate be executed physician and s the burial-transit		that initiated events c. The properties of the control of the con	onsequence of):					
09	ate be hysici he bu	edical	d						
387	artifica ding p		IF FEMALE: 23c. If yes, outcome of	programmy					
Box 687	ath ce attenc for us	cian	in the past 12 months?	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	rery Day Year
Э.	requires that the death certific been signed by the attending I should be detached for use as	Physician/M	1 Yes 2 No 4 Pregnant at til 9 Unknown 9 Unknown						
P.O.	that typed the detail	by P	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause given	n in Part I.		co use contribute to t	
ds,	equires	ted					1 Ves	2 No 3 Pro	bably 4 🗆 Unknown
00	law re nas be e 2 sh	Completed					24a. Was an autopsy	prior to co	psy findings available empletion of cause of
æ	sician: The law is certificate has k						performed		2 🗆 No
ita	siciar certif irecto	m	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		Othor	e of Death (Check on		-	
of o	g Phy er this eral d	-E:	27. Mann Leath 28a. Date of injury	2 ER/Outpatient 28b. Time of	28c. Injury at		5 Residence Describe how in	6 Other (Specification)	y)
u o	ath. or: Aft	licat	1 Natural 5 Pending (Month, Day, Y 2 Accident Investigation	<i>(ear)</i> injury	M 1 ☐ Ye	s 2 🗆 No			
Division of Vital Records,	or Atter fter de irecto n by ti	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (\$	- At home, farm, stre- Specify)	et, factory, office	28f	Location (Street City or Town, Str	and Number or Rura	l Route Number,
۵	. Hospital or Attendi 24 hours after death. Funeral Director: A eted filled in by the fu			les and a decided					
:	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examonly one) 3 Certifying Nurse Practioner: To the best of my 2 Medical Examiner: To the best of my 2 Medical	mination and/or investi	gation, in my opinion,	death occurred at the	time, date and pla	ace, and due to the ca	use(s) and manner stated.
i	To the within To the comple		29b. Signature and title of certifier	, Allowings, de	29c. License nu			Date signed (Month,	
			I las T Relevon in	D	0 24	1804	/	7 - 3/50/20	000
iig	=		30. Name and address of person who completed cause of deat	h (Item 23a) (Type, Pr	rint)	1		21/1-1	
4.	Stat		31. Date filed (Month, Day, Year) 32. Registrar's	Signature	C An	ngola	MD.	21401	
	Registra	_	JAN 0 4 2011 Elne	- 4	back				

		1 - State of Mar State Registrar		artment of Hea tificate of Dea		, 0	ene g. No. 🔿 🔘 🕕	10-1-0000
Physic Med		1. Decedent's Name (First, Middle, Last) John Royals Stewart			I	2. Date of Death Month December	Day V	3. Time of Death O
Exam		4a. Facility Name (if not institution, give street and number) 1224 Orchard Circle	·	4b. City, Town, or Loc Salisbur			4c. County of Wice	Death Omico
Funera Directo		244-52-6787 ¹™ ²□ F 79	In yrs. last birthday) Yrs.		Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, Y 12/14/1	931	B. Birthplace (State or Foreign Country) North Carolina
Maryland :8a-f show tified at	rector	Usual Residence of Decedent 10a. State	Oc. City, Town or Loc					10d. Inside City Limits 1 ☐ Yes 2 🔀 No
with the is 23a or 2	Funeral Director	10e. Street and Number 1224 Orchard Circle		10f. Zip Code 21801		10	g. Citizen of Wha	at Country?
Ind 21215-0036 Filed within 72 hours after death with the Maryland tall Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	۾ ۾	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Eve Armed Forces? 1 ☒ Yes 2 □ No If Yes, Give Year or Dates. Armed Forces?	lf o	As Decedent of Hispa Yes, specify Cuban, M	nic Orlgin? (Spec lexican, Puerto R pecify:	ify Yes or No- ican, etc.)		American Indian, White, etc. white
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) 4	(Give ki	ent's Usual Occupation ind of work done durin INOT use retired) Ger		g	Sb. Kind of Busir	ness Industry
faryland 212 should be filed within n and Mental Hygiene. r is marked other than raumatic event, the M	To Be	17. Father's Name (First, Middle, Last) William Murchison Stewart				(First, Middle, Mai Jane Wic	,	
	1	19a. Informant's Name/Relationship (Type, Print) Janis M. Stewart/spouse	1224	g Address (Street and a Orchard C				
time t. Page tment tant: I		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispos Springhil Gardens	T ^{ory} Memory	01/05/	/2011	Hebron,	
Departiment of the post of the		23a. Part 1. Enter the disease, or complications that caused the	-F3P 5	JI Snow Hi	II Ra.,	<u>Salisbur</u>	y, MD 2	Association
h certificate be executed tending physician and r use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant b. Due to (or as a condition of the condition of the condition of the condition of the cause of	onsequence of):				23d. Date o	of delivery
requires that the death certifications are asserted for use as should be detached for use as	Physician/M	The past 12 Hollus 1 Pregnant at ting 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but r	me of death 5	Other (specify)	Part I	00- Did t-b	Month	
requires the	eted by			aonymy saaso gronn		1 🗆 Yes	2 □ No 3 □	te to the cause of death? Probably 4 □ Unknown
ician: The law certificate has ector, page 2 s	e Completed	25. Was case referred to medical		OC Diagram		24a. Was an autopsy performed 1 Yes 2	d? prior	e autopsy findings available r to completion of cause of th? Yes 2 \sumbox No
g Physicia er this cert eral direct	e: To Be	examiner? 1 Yes 2 No	2 ER/Outpatient 28b. Time of	Othor		e 5 Residence		pecify)
To the Hospital or Attending Physician: The law requires that the death certification 24 hours afford ceath. To the Funeral Director, After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Certificate:	1 Autural 5 Pending (Month, Day, Ye 2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury-building, etc. (S	At home, farm, stree	M 1 ☐ Yes	2 🗆 No		t and Number or	r Rural Route Number,
To the Hospital within 24 hours . To the Funeral is completed filled	Medical	29a. Certifier 1 Certifying Physician: To the best of any (Check conly one) 2 Medical Examiner: On the basis of examiner: On the basis of examiner.	ination and/or investig	ation, in my opinion, de	ath occurred at the	e time date and n	lace, and due to	the cause(s) and manner stated
To the within 2 comple		29b. Signature and title of certifier		29c. License num	nber		Date signed (M	
IVA		30. Note an address of person the completed cause of death	13465			Jal	17/100	y, Md 2 180
Sta Registr		31. Date filed (Month, Pay Year) 2011 32 Registrar's	Signatury Ac	New York	<u> </u>	,		71

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ William Shehan Henry 2350 M Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Cente Vicomic If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F 707/1927 Country) Maryland 215-28-2593 83 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland Wicomico Salisbury 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral 1801 Mt. Hermon Road 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Martional If Yes, Give Valtional Year or Dates. Guard 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) health inspector State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William H. Shehan Sr. Ella Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1801 Mt. Hermon Rd., Salisbury, MD 21804 Betty Shehan/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 01/04/2011 Salisbury Crematory Salisbury, MD 22. Name and Address of Facility
Holloway Funeral Home Professional Association 21. Signature of Funeral Service Licenses 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or impury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the buriar-transit completed filled in by the funeral director, page 2 should be detached for use as the buriar-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Pregnant at time of death Yes 2 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Renal failur End Stage 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2. No Certificate: To 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DCA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 | only one) 29b. Signature and fille of certifie "Ing H56197 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) 100 E. CARROLL 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN05 Registrar

DHMH 17 Rev 7/2009

P.O. 1

Division of Vital

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State of Marvland / Department of Health and Mental Hydiene

			1 = For State Registrar	State of M	aryland /	Department of Certificate of		nd Mental H	ygiene	1 0	10000
	Physi	cian/	1. Decedent's Name (First, Middle, La			Certificate of	Death	2. Date of E	Reg. No.	I U	42300
1	Me	dical	Nettie J.	Smith				Pecen	Dav	7010	3. Time of Death
4	Exan	iner	4a. Facility Name (if not institution, give	street and number)		4b. City, Town,	or Location of I	Death	4c. County		21:25 1
	Funer	al	Peninsula Region 5. Social Security Number 16. S		II (Cmt)	or 5	alisb		Nic	com	100
	Directo		222-09-7236	□M 2 ^X □F		hday) If Under 1 Year Yrs. Months Days		Min. (Month, E	irth la <i>y, Year</i>)	9. Birthp Count	lace (State or Foreign
	nd wor		Usual Residence of Decedent 10a. State 10b. County					106/03/	1920	Vir	ginia
	arylar a-f sl	100			10c. City, Towr					10	0d. Inside City Limits
	or 28	ă	Maryland Wicomio	20	Sali	isbury				_	1 🛭 Yes 2 🗌 No
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director	711 Alvin Ave.			10f. Zip Code 2180	4		10g. Citizen of V USA	Vhat Count	ry?
	death item ner m	臣	11. Marital Status	12. Was Decedent Ev	ver in U.S.	13 Was Decedent of I	Jianania Orial d	(Specify Ves or No.			
36	affer al", or xami	d by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🔼 N If Yes, Give	No.	If Yes, specify Cub	an, Mexican, Pi	uerto Rican, etc.)		e - America k, White, et	n Indian, tc.
ŏ	hours natura ical E	lete	15. Decedent's Fo	Year or Dates,					Specify:	whi	te
215	in 72 e. nan "r	Completed	(Specify only highest gra	de completed)		Decedent's Usual Occup (Give kind of work done life. DO NOT use retired)	during most of	working	16b. Kind of Bu	siness Indu	ıstry
2	d with lygien ther ti	Be C	12	College (1-4 or 5+)	homemaker			domes	tic	
anc	oe file intal F ced of	P P	17. Father's Name (First, Middle, Last) John H. Merritt				18. Mother's I	Name (First, Middle,	Maiden Sumame		
Maryland 21215-0036	2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r traumatic event, the Med		19a. Informant's Name/Relationship (Ty				Lilly	y F. Jone	S		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Richard Smith Sr/	spouse	19b. 7	Mailing Address (Street : 11 Alvin Av	and Number or	Ryral Route Numbe	r, City or Town, St	ate, Zip Co	de)
Baltimore,	e 1 an of He If item rothe		20a. Method of Disposition		20b. Place of I	Disposition (Name of					
<u>ä</u> .	. Page tment tant: I		1 Bunal 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State)	cemetery	crematory or other place Cemetery		Date /01/2011	20c. Location -		
Bal	Departiment mapor mapor in injury inj	П	21. Signature of Funeral Service License		1				Salisb	ury,	MD
				Herry		22 HOTICAS 501 Snow	Hill R	d., Salis	olession bury, MD	al As 2180	sociation 4
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	Physician/ Medical		disease or condition resulting in death)	A CUTA	E I	MFERION	MYOU	AMPIAL	TOFARC	The o	nterval Between Inset and Death
مبسب	Examiner				onsequence of):				+ / ////	41	MAS
	- +	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co							
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9289	rificate be executed ng physician and as the burial-fransit	Medical									
89	E 50 a	W/u	F FEMALE: 3b. Was decedent pregnant 23	c. If yes, outcome of p	regnancy						
Вох	uearn ie atte ed for	Physician/	in the past 12 months?	1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death	3 Ectopic pregnancy 5 Other (specify)			23d. Date	,	
P.O.	th the	H A	9 🗌 Unknown	9 Unknown					Month) Day	y Year
σ.	gnec	्रे ह	art II. Other significant conditions conf	ributing to death but n	ot resulting in th	ne underlying cause give	n in Part I.	23e. Did tob	acco use contribu	te to the ca	ause of death?
Division of Vital Records,	oeen s	Completed						1 □ Y€	s 2 🗆 No 3	Probabl	y 4 Unknown
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Vita	is cert direct	o Be	examiner?	spital:		26. Plac	e of Death (Che			100 2	1140
of	h. After this funeral dii	27	. Manner of Death	1 Inpatient 28a. Date of injury	28h Time		4 Nursing F	Home 5 Resider	nce 6 Other (S	pecify)	
ion	leath. Ior: Al	<u> </u>	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Yea	ar) injury	work?	s 2 🗆 No	28d. Describe hov	injury occurred		
ivis	after death. Director: A in by the fu	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm,			28f. Location (Stre	eet and Number o	Rural Rout	to Number
Division of Vital	24 hours a Funeral Cleted filled	ig	Pa. Certifier 1 Certifying Physicia					City of Town,	State)		e ivanibei,
the Ho	within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page.		(Check 2 Medical Examiner	n: To the best of my ki On the basis of examin	nowledge, deat nation and/or inv	h occured at the time, da estigation, in my opinion, e, death occurred at the ti	ate and place, a	and due to the cause	e(s) and manner as	stated.	
10 th	within 2 To the comple		b. Signature and title of certifier	ractioner: To the best of	of my knowledge	estigation, in my opinion, e, death occurred at the til 29c. License nu	The same of the pic	ioo, and due to the C	ause(s) and manne	as stated,	
	1		Dr thm	muh.		191	9) 1)	29	d. Date signed (Mo	onth, Day, Y	'ear)
	I will	30.	Name and address of person who comp	pleted cause of death (Item 23a) (Type,	Print)	1/1		14/21	120	1/0
	Doc	1/	SERVIS & CHOUNT	\mathcal{H}_{l} .	100 E.	shore or.	SAU.	564M MU)		
	State Registrar	31.	Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	e del		/			
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Smith 2218PM Ann Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Recional Medical If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🗆 M 2 🕱 F Months Min. 03/25/1937 213-34-7811 73 Director Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Medical Fyamina mant to a start of the start 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Salisbury 1 Tes 2 No Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21801 27674 Crooked Oak Lane USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 X No þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Completed 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Stafford John A. Fink 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27674 Crooked Oak Lane, Salisbury, MD 21801 Wayne Smith Sr./spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Springhili Memory 4 ☐ Donation 5 ☐ Other (Specify) 12 11 2010 Hebron, MD Gardens 21. Signature of Frineral Service Lice Howay Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a co sequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Year 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 1 🗌 Yes 25. Was case referred to medical 8 B 26. Place of Death (Check only one) examiner? 2 X No 뎯 1 🗌 Yes Other: 1 X Inpatient 2 DER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours after To the Funeral Direct City or Town, State) Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5/11 NICLANS M.O.

Registrar

31. Date filed (Month, Day, Year)

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Registrar's Signature

State of Maryland / Department of He State of Maryland / Department of He Registramended item#10f, WCHD, SU, 1.4.1 Certificate of E		
1. Decedent's Name (First, Middle, Last) Physician	2. Date of De Month	Day Year
/Medical Weslyan Virginia Smith Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or I	12-24-	
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Director 232-60-7035 1□ M 2X F 81 Yrs. Months Days	Hours Min. 8. Date of Bin (Month, Da 8 – 12 –	ly, Year) Country) 1929 WV
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MD Wicomico Salisbury		10d. Inside City Limits 1X Yes 2 □ No
MD Wicomico Salisbury 10e. Street and Number 21804		10g. Citizen of What Country?
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105 Civic Avenue 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 11. Never Married 2 Married 1 1 Never Married 2 Married 1 1 Never Married 2 Married 1 1 Never Married 2 Married 1 1 Never Married 1	panic Origin? (Specify Yes or No , Mexican, Puerto Rican, etc.)	USA 14. Race - American Indian,
Armed Forces? If Yes, specify Cuban 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give 1 □ Yes 2 ☑ No		
1 Never Married 2 Married 1 Yes, Specify Cuban 1 Yes, Specify Cuban 1 Yes, Specify Cuban 1 Yes, Sive 1 Yes, Specify Cuban 1 Yes	Specify:	Spe B Mack
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Sales Clerk 17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle,	
Wesley Richardson 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street ar.	Nellie Mickey	
The part of the pa		y er, City or Town, State, Zip Code)
Frances Smith/Daughter 105 Civic Av	enue, Salisbi	ury, MD 21804
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place)	Date	20c. Location - City or Town, State
4 Donation 5 Other (Specify) Blue Ridge Mem	1/7/2011	Beckley, WV
1 Service Licensee 1 Service Licensee 1 Service Licensee 1 Service Licensee 1 Service Licensee 2 Name and Address Bennie Sm	of Facility 917 W. Is	sabella St.
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying,	ome Salisbury	y, MD 21801
Shock, or heart failure. List only one cause on each line. Inserting Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		Interval Between Onset and Death 5 y cars
Sequentially list conditions, flary, leading to initial data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d. FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1		
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		obacco use contribute to the cause of death?
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25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other.	26. Place of Death Check only or	
O = 1	4 Nursing Home 5 Resid	
C C C Manyer of Death C C Manyer of Death S □ Pending 1 ☑ Natural 5 □ Pending (Month, Day Year) 1 ☑ Natural 5 □ Pending Work? 1 ☐ Year Natural 5 □ Pending North Day Year)	es 2 No	ow injury occurred
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27. Manper of Death 1 Natural 2 Natu	City or Tow	m, State)
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1	, date and place, and due to the online, death occurred at the time, of	cause(s) and manner as stated. date and place, and due to the cause(s)
	number	29d. Date signed (Month, Day, Year)
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1 Na Mm		December 29 15 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month John A. Smith, Sr. Medical Dec 2010 9:05 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) an 20, 1927 1 3 M 2 F Months Days Hours Min. 213-22-5239 Director 83 Jan MD Usual Residence of Decedent show 10a. State notified at 10b. Counts 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD Worcester Berlin 1 Yes 2 No ö 10e. Street and Numbe 10f. Zip Code or than "natural", or items 23a or the Medical Examiner must be 10g. Citizen of What Country? Funeral 10624 Flower Street 21811 USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces XYes 2 NArmy Yes, Give þ 1 Never Married 2 Married Black, White, et Baltimore, Maryland 21215-0036 African-1 ☐ Yes 2 🔀 No Specify. Completed 3 Widowed 4 Divorced Specify Year or Dates American 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed, Hygiene. Elementary/Seconday (0-12) 9th Worcester County College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Board of Education Bus Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Clinton Smith Hattie Hudson other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Vivian P. Smith/wife 10624 Flower St., Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place! Paul's Cemetery 4 Donation 5 Other (Specify) 01/04/11 Berlin, MD Signatur - Funeral Service Licensee 22. Name and Address of Facility
Lewis N. Watson Funeral Home, PA D. Walso) 1618 West Road, Salisbury, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Annroximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ CONDIMAN disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infiniteliate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and the burial-tran resulting in death) Last Due to (or as a consequence of attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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Director: After this 4 Nursing Home 5 Residence 6 Other (Specify) funeral of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work' Accident
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	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death within 24 hours after death this certificate has been signed by the attending ompleted filled in by the funeral director, page 2 should be detached for use	Medical Certificate:	(Check 2 L	J Medicai Exam	sician: To the best iner: On the basis o	of examination	n and/or investi	gation in	my opinior	death occ	curred at th	ne time date a	and place	and due to	the equecal	s) and manner stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav GYORGY TIMKO Year Medical 12 2010 8:20 P. Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 808 BEDFORD STREET **CUMBERLAND** ALLEGANY Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 07/08/1945 Birthplace (State or Foreign Country) 1 X M 2 D F Days Months Hours Min Director 218-02-1567 65 HUNGARY Usual Residence of Decedent show 10a. State 10b. County the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD ALLEGANY CUMBERLAND 1 XYes 2 No 10e. Street and Number ō 10f. Zip Code er than "natural", or items 23a or the Medical Examiner must be 10g. Citizen of What Country? Funeral with 1 808 BEDFORD STREET 21502 U.S.A. hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ve 2X No þ 1 XNever Married 2 Married Black, White, etc. 1 Yes If Yes, Giv Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygier 7 is marked other t 12 COOK COUNTRY CLUB injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 (UNKNOWN) (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau DAVID CHRISTIFER / FRIEND 808 BEDFORD STREET, CUMBERLAND, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CUMBERLAND CREMATORY 12/31/2010 CUMBERLAND, MD Signature of Funeral Service Licensee 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. Bokule March & 202 GREENE STREET, CUMBERLAND, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Physician/ Onset and Death A.S.C.V.D. disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) executed and -tran Due to (or as a consequence of) resulting in death) Last burialattending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Yes 2 No the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypertension Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death? autopsy ers after death.

eral Director: After this certificate I filled in by the funeral director, pag. perform Yes 2 N 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 ☐ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work' ☐ Accident ☐ Suicide Investigation
6 Could not be 1 Tes 2 🗌 No Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D09157 Dec. 29, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) noss

State Registrar Snow,

JAN04

31. Date filed (Month, Day, Year)

M.D.

Deputy Med.

32 Registrar's Signatu

Ex.,

124 W. 3rd. St., Cumberland, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Josie Taylor Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center icomico If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Funeral Social Security Number 9. Birthplace (State or Foreign 1 M 2 TF 3-21-192 Country) 89 Director 182-26-6304 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits ems 23a or 28a-f sh r must be notified a 1X Yes 2 ☐ No Somerset Princess Anne MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Manokin Funeral 11974 Edgehill Terrace-Manor 21853 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces Black, White, etc. 0 þ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: see Black "natural", 3 Nidowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the 6 Housekeeping Private Families Page 1 and 2 should be filed with ment of Health and Mental Hygien tant; If item 27 is marked other it. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lloyd Savage Lena Savage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace Bagwell/Niece Ft. item 2 Bluestone Circle. Myers, FL33913 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important; If it any injury or o 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) erusalem Bapt Cem 2-31-2010 Temperanceville, VA 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Salisbury, MD 21801 Funeral Home 23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Approximate** Interval Between Immediate Cadse (Final disease of condition resulting in death) Onset and Death Physician/ C. diff Cohtis Medical Due to (or as a consequence of) Examiner Jepsis Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) by the attending physician and stached for use as the burial-transit Cause (Disease or linjury Tre rend ture that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month signed by the ar g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an Were autopsy findings available prior to completion of cause of certificate has autopsy performed? Yes 2 No death? 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 10 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at s after death. Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

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5.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print

AFZAL, M.D

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31. Date filed (Month, A

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12/22/10

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dominic Tucci Month Year 05:17 Medical 01 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical center cial Security Number 7. Age (In yrs. last birthday) If <u>Under</u> 8. Date of Birth **Funeral** If Under 24 Hrs. Birthplace (State or Foreign Country) 1 **X** M 2 □ Months Days Hours Min. Director 022-16-1154 89 0/04/192 Masachusetts Usual Residence of Decedent , or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene.
Important: If item 27 is anawfed other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Maryland Wicomico Salisbury 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 703 Schumaker Lane 21804 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Navy 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) worker federal government Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Carmine Tucci Grace Barucci 19a. Informant's Name/Relationship (Type, Print)
James Henson/nephew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12001 Green Tee Turn, Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 🗷 Cremation 3 D Removal from State 12/30/2010 4 Donation 5 Other (Specify) Salisbury Crematory Salisbury, MD Signature of Fuperal Service Lipensee 22. Name and Address of Facility Home Professional Association Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ XIA disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an nas within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page performed? death? Yes 2 L Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 2 140 ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Accident Accident Investigation 1 Tes 2 🗆 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medica 29a. Certifiei Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature a title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D68552 2010

State Registrar

AVI

30. Name and

1a fa

100 ECorroll St.

address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Solomon Goldsborough Tyler Month Year Jr. Medical 0400 AM 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5A/15 h UN 5. Social Security Number Camio d e horb m If Under **Funeral** Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 **K** M 2 □ F Months Days Hours Min. 214-10-0527 0473071920 Director 90 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland Wicomico Salisbury 1 K Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Maryland 21215-0036 21804 USA 1103 S. Schumaker Dr., Apt. 110 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 'natural", or þ Black, White, etc. 1 Never Married 2 X Married Year or Dates. Navy 1 ☐ Yes 2X No Specify: 3 🗌 Widowed 4 🗌 Divorced Completed Specify: white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiens Important: If Item 27 is marked other than any injury or other traumatic event. The Me Elementary/Seconday (0-12) College (1-4 or 5+) College Professor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Solomon Goldsborough Tyler Sr. Alma Aaron 19a. Informant's Name/Relationship (Type, Print)
Catharine Tyler/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1103 S. Schumaker Dr., Apt. 110, Salisbury, MD21804 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 1/3/2011 Salisbury, MD Signature of Funeral Service Licens Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due F lor a consequence of **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause E. Iar U. Cause (Disease or linjury Due to as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month 4 ☐ Pregnant : 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 1 NO 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 12 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this I Director: After this of in by the funeral d 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d

To the Funeral Direct

completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29d. Date signed (Month, Day, Year) W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21804 VY

Registrar

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For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 23:41 M JUANITA TURNER 2010 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs Funeral 7. Age (In vrs. last birthday) 8. Date of Birth MD Country) 9. Birthplace (State or Foreign 1 □ M 2 🕱 F 2-2-1946 Hours Director 64 219-46-4663 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10a. State items 23a or 28a-f shorer items 23a or 28a-f shorer items to be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Wicomico Fruitland 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 402 Ogle Avenue 21826 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. er than "natural", or ite the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Special lack 3 Widowed 4 Noivorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Laundry Attendent Deer's Head Hospital other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Samuel Lloyd Hull Gertrude Hackett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shenita Hull/Daughter J Moss Hill Lane. Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) Freedman's Meth Ce 1/1/2011 Tyaskin, MD W Funer rvice Li Page 122. Name and Address of Facility 917 W. Isabella St. any Salisbury. Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final anysician/ Onset and Death PNEOMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 3 DAYS Sequentially list conditions, Examiner Due to (or as a consequence or): If they, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
g ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by SUB-ARACHANOID HEMMORNAGE Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🖟 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has blirector, page 2 s autopsy 1 ☐ Yes 2 ☐ No Yes 2 N director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျ 1 🗌 Yes 1 Inpatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) hin 24 hours after death. the Funeral Director: After I mbleted filled in by the funer 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 24346 7016 DEC 17, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRISTUPHER KOLT7 22 SOUTH GAFENE ST. BALTIMORE, MO 21201 31. Date filed (Mor Day, Year) 32 Registrar's Signature State JAN 0 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death - 28 Physician/ Month Beatrice Thompson 2010 1:20 AM December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Worcester Berlin Nursing & Rehabilitation Ctr Berlin If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Year)
June 22, 1924 **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 😾 F Days Hours Country) 86 **Director** 219-14-3179 Usual Residence of Decedent show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Berlin Worcester 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 212B Branch Street 21811 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc.
African þ 1 Never Married 2 Married Beatrice Thompson Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ MANO If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Housekeeper unknown Various Motels Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Luther Mills Addie Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ashley Hayward/son 212B Branch St., Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) New Bethel UMC Cem 01/07/2011 Berlin, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Deat Physician/ 3 months Andrexia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ementia ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examir and -transit Atheroscleratio To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 X No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? ᅙ Coronary Completed 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Breast 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate 1 ☐ Yes 2 ☐ No Yes 2 XNo Division of Vital 25. Was case referred to medical director. Be 26. Place of Death (Check only one) 2**X** No Other: 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge death date and place, and due to the eause(s) and marrier as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year,

State Registrar Bunz

32. Registrar's Signat

H 0070020

9715 Healthway Dr., Berlin, MD

December 28, 2010

21811

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Diane Ceruzzi, D.O.,

JAN 0 4 2011

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of dea(h) (tem 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Year Month Elizabeth 5:57 F. M Recember 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 1 □ M 2 🖾 F Months Days Hours 152-50-8569 62 Sept. Chile 1, 1948 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b Count 1 ☐ Yes 2 X No Frederick Frederick Maryland 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? United States 1300 Appletree Court 21703 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 Yes 2 X No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Computer Operator Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hector Jana Elena Carrasco 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1300 Appletree Court, Frederick, Maryland 21702 Hugo Valenzuela / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5 Other (Specify) Stauffer Crematory Inc. 12/31/10 4 Donation Frederick, Maryland 22. Name and Address of Facility 21. Signature of Juneral Service Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick,Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 | Fetal death in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

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Director: After death.

the Hospital or Attending

after hours Funeral

24

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The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

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Baltimore, Maryland 21215-0036

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25. Was case referred to medical	26. Place of Death (Check only one)								
examiner? 1 Yes 2 No	oital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Oth	er: 4 🗌 Nursing Ho	me 5 Residence 6	☐ Other (Specify)				
27. Manner of Death 1 Natural 5 Pending 2 Accident 28	28a. Date of Injury (Month, Day Year) 28b. Time Injury	y Wor		28d. Describe how injury	occurred				
3 Suicide 6 Could not be determined	8e. Place of injury - At home, farm, s	street, factory, office		28f. Location (Street and	d Number or Rural Route Number,				

and due to the cause(s) and manner as stated.
ed at the time, date and place, and due to the cause(s)

29c. License number RES-000 29d. Date signed (Month, Day, Year) DETEMBER 27, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUMITHA GANJI 600 North Wolfe St, Baltimore, MD, 21287

State Registrar 31. Date filed (Month, Day, Year) JAN

29b. Signature and title of certifier

32. Regist ar's Signature

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			State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No.										nn		
			riegistra								Date of Death 3. Time of Death				
н	Physici		Nolson	an Vorst			Month ecember	Day Year		12:42	AM				
1	/Medio								Location of Death			4c. County of Death			
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	Director		221-18-7542	1 X M 2 □ F	80	Yrs.	WOTTINS Days	Hours	0	1-09-1	930	Mil	ford,	DE	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 23s or 28a-f show any Injury or other traumatic event, It is Marical Experiment and Injury or other traumatic event, It is Marical Experiment and Injury or other traumatic event, It is Marical Experiment and Incoming any Injury or other traumatic event, It is Marical Experiment and Incoming any Injury or other traumatic event, It is Marical Experiment.	Funeral Director	Usual Residence of Decedent 10a, State 10b. County		10c Ci	ty, Town or Loc	cation					14/	od. Inside City	Limite	
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Baltimore, Maryland) Be	17. Father's Name (First, Middle, Cornelius Va						ra S		iden Surnami	9)			
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30			IND Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S				natory or other place Lows Cen	n. 01	1/02	/2011	Seaf	ord,	DE		
≣			21. Signatur of Fundal Service	7		22	. Name and Address	1							
m			21. Signatur of Fundamental Home Cranston P O Box 967, Seaford, DE 19973												
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	To the hospital or Attending Property of the Funeral Director: After it completely filled in by the funera	Me	29b. Signature and title of certifier 29c. License number								29d. Date signed (Month, Day, Year)				
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Touck !10									10						
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